Safe Durham Partnership Board

Domestic Homicide Overview Report

DHR/002

An Independent Report concerning

the death of Adult A in 2011

Independent Chair: Claire Sullivan

February 2013

Contents

Section 1: Introduction

1.1 The commissioning of the review

1.1.1 This overview report has been commissioned by the Safe Durham Partnership Board concerning the homicide of Adult A in 2011, committed by his sibling Adult B[1]. This report has been compiled by Mr Russell Wate QPM MSc, supplied by RJW Associates, who is independent of the Safe Durham Partnership and all agencies associated with this overview report. He is a former (retired) senior police detective and his expertise in homicide investigations including Domestic Homicide and child protection has received national recognition. He travels internationally presenting courses to healthcare professionals and law enforcement agencies. He is the current Independent Chair of the Peterborough Safeguarding Children's Board (LSCB) and has previously been the Independent Chair of the Hammersmith and Fulham LSCB. He has completed a number of domestic homicide reviews.

1.1.2 The Safe Durham Partnership appointed an independent chair who was Claire Sullivan, a Consultant in Public Health for County Durham. Paragraphs 32-34 of the Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2013) states: "the review panel chair (and author, if separate roles) should, where possible be an experienced individual who is not directly associated with any of the agencies involved in the review". The chair is independent of all of the organisational areas of business that have supplied either IMR's or reports for the purposes of the review.

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

1.1.4 The death of any person in circumstances such as herein is a tragedy. In this case the family continue to grieve not just for the loss of their son but also for the long term effects by the fact that the death was at the hands of his sibling, who in effect they considered that they have also lost. The family of Adult A and Adult B have been consulted during the review process and their views are commented upon accordingly within this document. Contact with the family was undertaken by the Independent Chair of the Domestic Homicide Review (DHR) panel, Claire Sullivan with the support of the Police Family Liaison Officer. The overview is grateful for this input and the information obtained as a consequence of this contact.

1.1.5 The following agencies have contributed to the Domestic Homicide Review either by an Individual Management Review (IMR) or alternatively by report (Rp) by agreement of the Independent Chair.

[1] The delay in notification to the Home Office was due to a communication error between the police and the CSP concerning the adoption of the statutory guidance in respect of 'family members'. This has had no detrimental effect to the overall process.

- Durham Constabulary (IMR)
- County Durham Youth Offending Service (CDYOS) (IMR)
- Durham County Council, Children and Adults Services (Education)(Rp)
- Durham County Council, Children's Safeguarding Team (IMR)
- NHS – GP Practice (Rp)(Provided by the DDES CCG)
- Durham Tees Valley Probation Trust (IMR)
- Tees Esk and Wear Valleys NHS Foundation Trust (TEWV) (IMR)
- County Durham & Darlington Foundation Trust (CDDFT) (IMR)
- HM Prison Service (HMPYOI) (IMR)

1.2 The review panel

1.2.1 The domestic homicide review panel comprised the following professionals

- Claire Sullivan, Independent Chair
- Paul Goundry, Durham Constabulary
- Margaret Brett, Tees Esk Wear Valley NHS Foundation Trust
- Hazel Willougby, Durham Tees Valley Probation Trust
- Gill Eshelby, Youth Offending Service, Durham County Council
- Karen Robb, Children's Services, Durham County Council
- Diane Richardson, Durham Dales, Easington and Sedgefield Clinical Commissioning Group
- Maureen Grieveson, County Durham and Darlington Foundation Trust
- Caroline O'Neill, Durham County Council, Education
- Bronia Banecki, Low Newton Prison

1.2.2 The Independent Chair of the panel, was independent of all of the organisational areas of business that have supplied either IMR's or reports for the purposes of the domestic homicide review.

1.3 Reason for conducting the review

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

O*f the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by—*

(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death'

1.3.2 For the purpose of this overview report the definition of domestic violence is in accordance with the cross-government definition:[2]

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

The definition was changed in March 2013 and is detailed below:

'Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality'.[3]

1.4 Terms of reference

1.4.1 The Safe Durham Partnership Board agreed that in this case the death met the criteria of the act and statutory guidance and commissioned a Domestic Homicide Review (DHR). The following terms of reference (TOR) has been determined by the Chair of the review panel:

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

1.4.2 The following additional terms of reference were applied by the panel both for the individual IMR's and this overview report.

1.5 Purpose of the review

- *Establish the facts that led to the incident in 2011 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family.*
- *Identify what those lessons are, how they will be acted upon and what is expected to change as a result.*
- *Establish whether the agencies or inter agency responses were appropriate leading up to and at the time of the incident in 2011.*
- *Establish whether agencies have appropriate policies and procedures to respond to domestic abuse and to recommend any changes as a result of the review process. Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts.*

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

[3] The new definition for domestic violence and abuse was published in March 2013 but is not the basis of this Domestic Homicide Review and Overview report due to the date of the commissioning of both the review and overview report. (A review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by—(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or(b) a member of the same household as himself)

1.6 Scope of the review

- *Seek to establish whether the events in 2011 could have been predicted or prevented.*
- *Consider the period of 8 years prior to the events (from 1st January 2003) subject to any information emerging that prompts a review of any earlier incidents or events that are relevant.*
- *Request Individual Management Reviews by each of the agencies defined in Section 9 of the Act, and invite responses from any other relevant agencies or individuals identified through the process of the review.*
- *Seek the involvement of the family, employers, neighbours & friends to provide a robust analysis of the events. In this case the mother and grandmother of Adult's A & B were the one's consulted.*
- *Take account of the coroners' inquest in terms of timing and contact with the family[4].*
- *Produce a report which summarises the chronology of the events, including the actions of involved agencies, analyses and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.*
- *Aim to produce the report by the end of November 2013, to enable presentation to the Safe Durham Partnership Board in November 2013, responding sensitively to the concerns of the family, particularly in relation to the inquest process, the individual management reviews being completed and the potential for identifying matters which may require further review[5].*

1.7 Subjects of the review

- Adult A and Adult B
- Adult A – Age at death 24yrs
- Adult B – Age at incident 21yrs
- Other family members are referenced accordingly and for context.

1.8 Objectives

1.8.1 The purpose of the IMR's which form the basis for the DHR is to give an as accurate as possible account of what originally transpired in an agency's response to Adults A and B, to evaluate it fairly, and if necessary to identify any improvements for future practice. The IMR's have also assessed the changes that have taken place in service provision during the timescale of the review, given that practice goes back to 2003. They have considered if changes are required to better meet the needs of individuals at risk of or experiencing domestic abuse. Such contextual changes are not discussed in detail within this overview, other than where it is considered necessary by the author of this report and where such change has led to significant change in practice that requires comment – both positive and negative.

[4] HM Coroner later confirmed that the inquest would not be resumed following the conclusion of the criminal case

[5] This DHR will be presented to the March 2014 SDPB meeting as there were a number of DHRs underway in the County and as the Board meet bi-monthly they believe it was important to take only one review at each meeting in order to give sufficient time to discuss the findings and recommendations

1.8.2 This overview report is based on the IMR's undertaken by each agency involved with the case. Chief Officers in each agency identified professionals who are independent from any involvement with the victims, family or the alleged perpetrator. The IMR's have been signed off by a senior responsible officer in each organisation who is responsible for the maintenance of and strategic ownership of any actions that are approved by the Safe Durham Partnership arising from the DHR. Where an agency IMR has made recommendations these will be managed by the individual agencies and monitored by the Safe Durham Partnership Board through the Domestic Abuse and Sexual Violence Executive group (DASVEG).

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

1.8.4 An executive summary will also be presented by the overview author for publication in accordance with policy. Relevant family members of the adults will be briefed about the report in accordance with policy and practice of the Safe Durham Partnership Board and such consultation will take place prior to publication of the respective report and executive summary.

1.9 Background

1.9.1 In 2011 and 2012 a total of 540 murders were committed in England and Wales. Of these 176 were identified as being 'domestic homicides'. Historically, very few domestic related homicides were reviewed. In 2011 the Home Office published the Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews. Within County Durham and Darlington a multi-agency protocol was established in 2007 whereby agencies agreed to cooperate in carrying out homicide reviews where the victim and perpetrator were, or had been, involved in an intimate personal relationship with each other. Since that time a small number of reviews have been carried out and agencies have worked well together to act on the findings.

1.9.2 The Safe Durham Partnership was formed in April 2009 following Local Government reorganisation. Prior to this there was a long history of partnership working across County Durham at both a countywide level and through the five district based Community Safety Partnerships. The vision is for a County where every adult and child will be, and will feel, safe. Working in partnership is essential in order to achieve this vision. There is a strong history of partnership working across County Durham since the introduction of the Crime and Disorder Act in 1998. A commitment to working in partnership has ensured real and tangible improvements to the quality of life of their communities[6].

[6] Safe Durham Partnership plan 2011-2014

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

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

1.9.5 Alcohol Harm Reduction is also a priority for the Safe Durham Partnership and the Health and Wellbeing Board. Alcohol was identified as a significant factor that cuts across all other priorities. Alcohol and substance misuse are problematic in their own right and aggravate other crimes and disorder. They can lead to people becoming more vulnerable to offences of assault, while many victims of abusive partners can also suffer problematic substance misuse themselves. Within the Safe Durham Partnership Plan for 2011-14 there are two areas that are of particular relevance to this review:

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

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

Section 2: The Facts

2.1 Case specific background

2.1.1 The family reside in in a small town with a population of approximately 12,000. They had previously resided in a larger town in the region.

2.1.2 The death of Adult A (who was 24yrs at the time of his death) occurred in 2011. During that afternoon Adult B (21yrs) was engaged in messaging on the social network site 'Facebook' with someone she knew. In the communications she indicated that she wanted to go back to prison because she had no friends. During this social messaging, Adult B made various threats about stabbing someone that night, although she did not indicate who. Later that same evening Adult A and Adult B were at a planned 'party' at Adult A's home. They and other guests were consuming quantities of alcohol. An argument broke out between Adult A and Adult B and during this Adult B took possession of a knife and stabbed Adult A causing him fatal injuries.

2.1.3 Adults A and B are biological brother and sister and have a half-sibling (identified as Adult C for the purpose of this overview). The formative years of both Adult A and Adult B have been described by agencies in their IMR's as chaotic and challenging and that this lifestyle continued into their adulthood. Chaotic households are a term used by social workers in children's social care, stemming from serious case reviews of child deaths and abuse. Some of these characteristics which fit this case are low income, poor housing conditions, children missing education, low take up of statutory services officers, criminality, substance misuse, plus domestic abuse[7]. Chaotic families are now better known and described through the 'Think Family' Programmes. [8]

2.1.4 The father of Adult A and B was murdered when they were just 11 and 8 years of age respectively. There is limited information concerning this event, although the information received for this overview indicates that he was violently beaten in an attack. However, taking this event into context the nature of such a significant event occurring would certainly have been life-changing for the family unit and there is an indication from family and professionals that the murder of their father had a profound effect on the two adults given both the circumstances.

2.1.5 Both adults and the elder male half-sibling, Adult C appear to have grown up in a home environment of abuse, neglect, and alcoholism and on occasion's drug misuse. There is reported by the agencies that there was minimal income to the family household throughout and this appears to have contributed to the overall conditions that the family experienced. There is information that the maternal grandmother was a highly influential member of the family. There is mention of tensions between the family and the local community with sporadic anti-social behaviour and violence occurring. The family home had been attacked and damaged on at least one occasion.

2.1.6 In addition there is evidence of domestic abuse between the mother and father of Adults A and B prior to his death that both Adults were exposed to and on occasions was witnessed by them.

2.1.7 Contact with support agencies although frequent was sporadic if only on the part of the family in acceding to or recognising the intervention opportunities. A number of the individual management reviews identify numerous occasions where both adults and other family members failed or refused to engage with them despite the best efforts of the respective professionals. This overview report will examine and comment on the statutory interventions where appropriate.

2.1.8 The mother of the Adults A and B in a meeting with the Chair of the DHR panel admit that her alcoholism was a significant factor in the upbringing of all the children. In self-admittance of this fact she also expressed her concerns that whilst alcoholism is recognised by professionals it is an area where a lack of useful intervention existed at that time.

2.1.9 A significant family comment that perhaps exemplifies the manner with which the two adults in particular were brought up was that they believe that they did not get sufficient support from agencies. Although no single agency is cited they were, *"brought up not to let things get to you"* and all the support was maintained from *"within the family*". This is perhaps indicative of the fact that despite interventions, the family believed that they were actually in control when this was to the contrary and although the family were presented with opportunities they effectively did not take

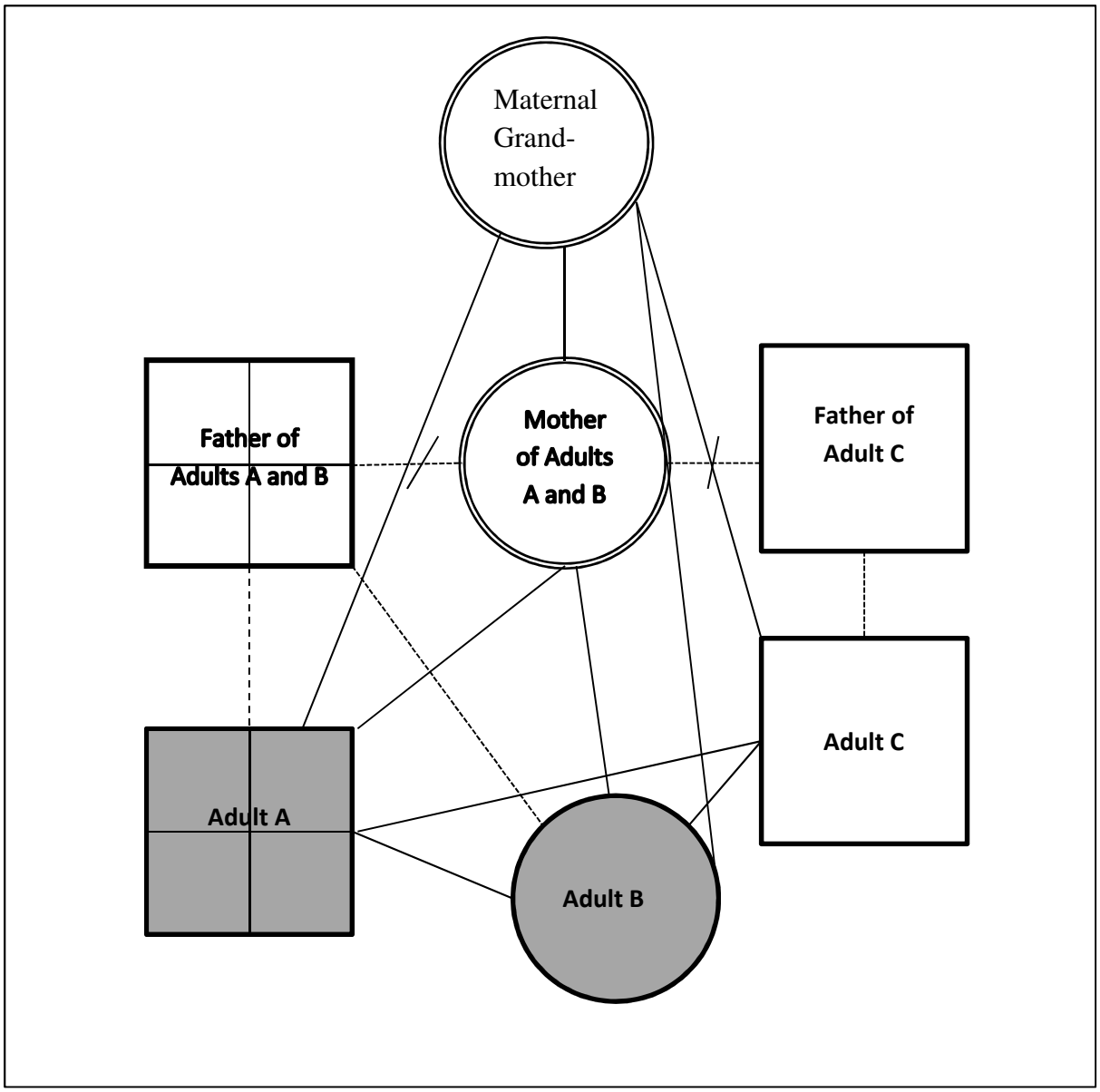
[7] Marion Brandon et al, Analysing Child Deaths and Serious injury through Abuse and Neglect: what can we learn? A biennial analysis of serious case reviews 2003-2005.
[8] Think Family: Improving the Life Chances of Families at Risk, – Department of Children, School and Families. 2008

any support offered. This is a key consideration when examining the parenting skills that the interventions and support were aimed at. This may be an issue which will be explored in comment and may assist in identifying future intervention opportunities for the respective agencies in dealing with similar circumstances.

2.2 Chronology

2.2.1 The author is grateful for and refers to the chronologies provided by the IMR authors. Using these chronologies an integrated chronology has been compiled. Any reference made to the chronologies will be contained within the body of this overview report and is not subject of specific separate comment.

2.3 Family composition



○	□	△	X	⊕	□	●	■	___ __	Enduring Relationship
								- - - -	Transitory relationship
Female	Male	Pregnancy	Abortion or Miscarriage	Deceased – Cross is placed inside gender symbol		Subject		/	Separation
								//	Divorce

2.4 The Individual Management Reviews

2.4.1 Although the reviews are discussed in more detail within the analysis of this report this is a summary of the information and contents of the individual reports.

2.4.2 Durham Constabulary

The Author of the report is an experienced senior detective and is both independent of the investigation concerning the murder of Adult A by Adult B and any agency contact or intervention.

The Constabulary detail what is described by a number of other agencies professionals as chaotic and emotionally troubled family with inconsistent parenting. There is evidence of alcohol and drug abuse and low levels of criminality linked to substance abuse. Both adults A and B have criminal convictions for offences of violence.

The author makes a number of observations and organisational specific recommendations and links actions to the provision of support from partnership agencies which are indicative of the need to ensure a joined up approach by the responsible agencies for future learning.

In current context the re-structuring of Durham Constabulary's response to dealing with the complexities of public protection led to the creation in 2011 of a Central Referral Unit, professionalising the screening of matters such as domestic violence, child protection and mental health matters.

2.4.3 County Durham Youth Offending Service (CDYOS)

The author of the report is an experienced senior manager having some significant background in the criminal justice arena and is also a qualified social worker. The author is independent of agency involvement with the victim and perpetrator.

The report details several occasions of engagement with the perpetrator and victim over the period from when they were aged 17 and 16 years respectively and that the background to the family unit was both violent and aggressive and there is evidence of self-harm on the part of both adults.

In context the manner with which young persons are moved through the criminal justice interventions processes have changed considerably since the inception of contact with the family. Consequently the author does not recommend any organisational specific recommendations due to such contextual statutory and procedural changes that have taken place in more recent years.

2.4.4 Durham County Council – Children and Adult Services (Education)

The author of the report is the Governance and Schools Workforce Liaison Manager for the Education Service within Children and Adults Services. The author provides support to schools in relation to a range of workforce issues and manages the team that provides a professional clerking service to schools. The author is independent of the case.

Access to the education services was limited on the parts of both Adults A and B and little viable information exists. Both Adults were excluded from secondary school. Adult A for repeated defiance, abusive language, a physical attack on a student and threats to the staff. Adult B for persistent

disruptive behaviour. Although not reported in any detail within the report it is understood that both received some limited personal tuition at home following exclusion.

There is reference to Adult A having Special Educational Needs, and that he had difficulty in relating to adults and having behavioural issues. The content of the report is limited due to the lack of information available.

2.4.5 General Practitioner (DDES CCG)

The author of the report, prepared on behalf of the Durham Dales, Easington and Sedgefield Clinical Commissioning Group (DDES CCG) is a senior nurse for Safeguarding Adults for the three Clinical Commissioning Groups across County Durham and Darlington. The author has experience in the safeguarding of adults and has previously been a senior manager in adult safeguarding for a local authority.

The report details the contact by GP Practice with Adults A and B and reports matters outside of the timeframe in support of contextualising the background.

The author is able to show that despite engagement with services, the family individuals frequently failed to attend follow up appointments and take up offers of support.

2.4.6 Probation Service – Durham Tees Valley Probation Trust

The author of the report is an experienced lead manager for public protection and MAPPA, has previous experience as the author of IMR's for the Probation Service and is a panel member for unrelated serious case reviews and domestic homicide reviews. The author is independent of the case.

The Probation service appear to have had the most frequent of all the reporting agencies contact with both Adults A and B over the timeframe, with an extensive chronology reflecting that information.

The report references the Probation Services Serious Further Offences process concerning the management of Adult B that was previously reported back to the National Offender Management Service (NOMS) although this is not extensively reported on within the IMR.

The report signposts the Probation Services most significant contact with Adults A and B, in particular the MAPPA arrangements in this particular case. The author does not make any agency specific recommendations arising from the IMR. However the overview author recommends that the Durham and Tess Valley Probation Trust integrates the previously identified issues arising from the serious further offence report to the IMR.

2.4.7 Durham County Council Social Services – Adult and Children's Safeguarding Services

The safeguarding report is compiled by an experienced team manager, who has a background in a range of roles within social care with families and children. The author has no personal knowledge of the subjects and family and is independent of the case.

The information indicates that the family were consistently poor in presentation throughout their contact with the safeguarding services. The family had a significant history and background of community problems that led to them moving out of their home. This appears to have been peppered by episodes of criminal damage to their property and anti-social behaviour. The family lifestyle is best described as being chaotic. The report also indicates that Adult B was subject to alleged physical abuse at the hands of her step-father.

The review indicates a lack of management oversight of the case involving the family and historical missed opportunities for multi-agency intervention. However given these were a number of years ago significant changes have been made since that time.

2.4.8 Tees Esk and Wear Valleys NHS Foundation Trust (TEWV)

The Trust is one of the largest specialist providers of mental health and learning disability support to approximately 1.6 million service users in Durham, Teesside and North Yorkshire.

The author of the report is a senior nurse for safeguarding adults and has extensive previous experience in learning disabilities forensic services.

The author has expertise of the investigation of serious untoward incidents, service reviews and standards audits and is independent of the case having not worked in any of the services that the victim and perpetrator accessed.

The Trust had brief contact with the perpetrator and victim where some care and treatment was provided.

One of the findings from the IMR are that at the time of involvement, neither the crisis resolution team or the criminal justice liaison team, recorded their involvement on a trust wide IT system. Therefore it was not possible for each team to know of the others involvement, this has now been resolved.

2.4.9 HM Prison Service (HMPYOI Low Newton)

The author of the report has been directly employed by the HM Prison Service in a management role since January 2006, both in resettlement and offender management functions. The author is independent of the case and has had no direct contact or involvement with either of the main subjects in this case.

The author has not been able to interview key staff members involved in the history of the case due to transitions although all relevant records were available and form the basis of the IMR.

The prison service has made recommendations within their IMR in relation to information sharing between mental health and the Offender Management Unit and recording decisions about risk management, which they have actioned.

2.4.10 County Durham and Darlington NHS Foundation Trust (CDDFT)

The author of the report is a Registered General Nurse and is currently a Senior Nurse, Safeguarding Children training, has extensive professional qualifications and has previously been the author on

behalf of the Trust of IMRs and Serious Case Reviews which are a statutory process through the Children's Act of 2004 to learn lessons from the deaths or serious injuries to children.

The author is independent of the case and the IMR details the contact with the respective adults over the review period, which provides concise details and information concerning instances of treatment and attendance at the Trusts accident and emergency departments and in respect of Adult B, school nursing records.

In line with the national NHS Records Management policy, school records are destroyed when the individual reaches the age of 25 and consequently no school nursing records exist in respect of Adult A.

2.5 Summary of facts in the case

2.5.1 Adult A was murdered by Adult B in 2011. The criminal trial of Adult B was held in 2012 and having pleaded guilty to the charge of murder, Adult B was convicted and sentenced to a minimum term of 12 years imprisonment.[9]

2.5.2 The overall lifestyle of the family unit is reported by several of the agencies in their IMR's as being "chaotic" and "challenging", although the agencies do not provide a definition for this description, this is best known through the research from reviews of child death and abuse and now through the 'Troubled Families' programmes. The formative years of the two adults and an older half-sibling were within a home where domestic abuse between their mother and father (and later step-father), alcohol misuse by members of the immediate and extended family, low income and a hostile environment were features of everyday life. There is an indication that the maternal grandmother was a major influence within the family and in particular over the mother of Adults A and B. There is frequent evidence of the movement of both adults A & B between their home and that of the maternal grandmother.

2.5.3 The natural father of both Adults A and B was murdered in a brutal attack that would appear to have had a profound and enduring effect on both the adults that may not have been fully recognised by professionals working with the family. At the time of his death, Adult A would have been 11 years of age and Adult B just 8years old. There is little information concerning the murder of their father. Following his death the mother had another relationship. This partner of the mother appears regularly referenced as the 'step-father' although the actual relationship with the mother of Adults A and B is not clear. Adult B appears to refer to him as her father within her conversations with professionals. It is suggested that although the 'step-father' worked, the main income to the mother was from state benefits as she was not employed.

2.5.4 Their half-sibling, Adult C, had a different father and there is minimal reference to that relationship within the wider context of the family unit. There are references to violence and aggression within the household that involved the siblings with each other and against the mother.

2.5.5 The IMR's have sought to examine information concerning the family extending back to 2003; the rationale for this date was the initial contact with the criminal justice service for Adult's A &B.

[9] The minimum sentence to be served in full before adult B will be eligible for a parole application.

Although comment is made on family background and composition dating back beyond this which is particularly useful to provide oversight and therefore providing further context.

2.5.6 In 2003 Adult A was aged 15/16 and Adult B was aged 13, in what would have been a particularly influential time in their development into adulthood, so it was felt important to consider agency involvement from this time.

2.5.7 In evaluating in more detail the IMR's provided for the DHR, the overview author has examined each IMR and sought to identify the key themes that have arisen. The overview report does not intend to rehearse the full content of the respective IMR's as these are for the purposes of individual agencies.

2.5.8 Both Adult A and Adult B attended accident and emergency in separate and unrelated incidents in 2003. Adult A in early 2003 and Adult B in late 2003. Both of them had taken an overdose of their mothers prescribed medication. Both of them were referred to the Child and Adolescent Mental Health Services respectively. At that time (2003) there was no school nursing service available for children excluded from school and consequently Adult A, who was excluded from school, would not have received any external support as an excluded child. The CAHMS service did engage with Adult B although engagement with her was difficult throughout the period of involvement and staff tried a number of ways to engage, this was within the clinic environment, school environment and with the help of a social worker who became involved following child protection procedures.

2.5.9 In 2003, following the reported overdose of his mother's prescribed medication by Adult A, the clinicians dealing with his admission, completed a child protection information form. Although this is good practice, it is unclear if this information was shared or actioned when received by the Senior Nurse Child Protection in CDDFT. Four months later, Adult A, aged 15, presented at A & E and reported that he had been drinking bottles of beer. It was identified then that he had not attended for his psychiatric appointments made following his attendance in the earlier incident. This was not referred to the Senior Nurse Child Protection and consequently no other referrals were made, for example to social services. The overview author does acknowledge that school records no longer exist in respect of Adult A due to the retention policy.

2.5.10 In 2003, Adult A then 16yrs old was admitted after an alleged assault, where he had been knocked unconscious. Little is known about the circumstances of this event and the CDDFT report indicates that no referral was made to Social Care. This was the third incident involving Adult A in a relatively short period of time.

2.5.11 In 2003 the Social Services Children Safeguarding team received two separate referrals concerning Adult B then aged almost 14yrs from Education and Children Mental Health Service (CAMHS) respectively. Both had expressed concerns over Adult B's recent presentation, in particular at school as *'deteriorating significantly'*. It was apparent that she had hygiene issues although the catalyst for the referral was principally that Adult B had been hospitalised having taken some of her mother's anti-depressant tablets in what was described as an overdose or attempted suicide. She had in fact taken a very small amount of the tablets. She admitted that she had no intention of killing herself. CAMHS shared the information concerning the incident to the Senior Nurse Child Protection. Overall the process of sharing and notification between agencies was good.

2.5.12 During the admission process for Adult B at hospital, as referenced within the CDDFT report, Adult B's mother admitted that she was consuming in the region of one litre of vodka a day. How accurate such an admission was is a point of issue as it is acknowledged by professionals that individuals with alcoholic addiction tend to underestimate their level of misuse. However, it was apparent from this information that Adult B was in fact her mother's carer, supporting her not only for her alcohol dependency, but also from mental health issues. Adult B was just 14 years old at this time.

2.5.13 Adult B was consequently referred to CAMHS and also assessed by a key worker from the Social Services Safeguarding team. However it appears that the assessing worker was in fact an unqualified practitioner at that time. The mother refused to engage with the Child and Adult Services and a few days before Christmas, she also attempted suicide herself by overdose and was hospitalised.

2.5.14 The initial assessment by social services was not commenced until 2004, some 5 weeks after the initial referral. Although not contextually reported within the respective IMR the overview author for the Children and Adult Services acknowledges that, whilst not excusing it this seasonal reporting *may* have had an effect on the initial response by the agency. Although the home environment was identified as *'poor and as having a propensity for violence'*, no actual risk assessment of the child (Adult B) was carried out when circumstances outlined that this should have been the case. It was recorded that the child protection thresholds *'had not been met'*, however the overview author suggests that had the intervention been more timely given all the circumstances, the overall picture may have been different. The 5 weeks from the initial reporting to intervention was a slow overall response, and outside the statutory timescales for completion of assessments.

2.5.15 The Children and Adult Safeguarding (CAS) IMR indicates that there was "*regular contact between agencies, but only one meeting".* Other than the initial assessment there was no Core Assessment[10] made, and significantly, no management oversight of the progression of the case. The records of contact with the family, in particular the mother and Adult B in the following months that progress into late 2004 show that Adult B 14yrs was disruptive within the home and also in school. There were clear behavioural issues.

2.5.16 During this time Adult A was imprisoned for un-related matters. Although the Safeguarding records show frequent contact with the mother and Adult B, the focus was to ensuring that Adult B attended her CAMHS appointments.

2.5.17 When the then un-qualified worker was asked specifically concerning the involvement with the family and Adult's A & B in particular during this period, the worker was unable to recall any specific details but accepted that the notes were made by her. The remit of the worker at the time appeared to be focussed more to ensuring that the mother and Adult B got transport to and from

[10] A Core Assessment is defined as an in depth assessment which addresses the central or most important aspects of the needs of a child and the capacity of his or her parents or caregivers to respond appropriately to these needs within the wider family and community context. The Core Assessment must build on the Initial Assessment, utilise any prior specialist assessments that may have been carried out and be completed within 35 working days of its commencement. The Core Assessment is a tool for Social Workers to use to bring clarity and purpose to their intervention with children/young people and their families. It is a multi-agency tool that should be contributed to by all the professionals involved with the child/young person and their family.

CAMHS and that Adult B was provided with some basic and essential needs for a young girl that appeared to be consistently lacking in her day to day life, such as toiletries, make-up and clean bedding.

2.5.18 When examining the number of contacts within a relatively short space of time in early to late 2004 by Children's safeguarding services there were indications that the household had complex needs and the superficial intervention was of little value in helping this family.

2.5.19 There is information from the IMR's that the conditions that the family 'existed' in were described by the worker as poor and this perspective continued throughout the visits made by safeguarding services. There appears to have been little or no improvement in the home environment and where the records indicate that the bedroom of Adult B was described as being 'deplorable' and assistance was given to the family in order to improve the conditions.

2.5.20 Opportunities to gain a clearer insight into the family unit were overlooked from this time where far more should have been known so that a picture of what it was like for the children in particular was understood by professionals. In context, protocols that now exist in accordance with Working Together[11] would almost certainly have triggered action.

2.5.21 As Adults A and B grew up, their behaviour reflected the emotional and continued difficulties of their upbringing and it appears that both misused alcohol as they progressed through their teenage years. Alcohol misuse has been an enduring matter for both adults A & B and not surprisingly was a significant feature within their personal relationships. An admission made by the mother of the adults to her severe alcohol addiction made to the panel chair as part of this review process is no doubt a key contributory factor to the home environment which gave rise to the family's tacit acceptance of the use of alcohol as being part of everyday life.

2.5.22 Looking further at the Primary Care IMR (DDES CCG) the author indicates that there was a *"reluctance to engage on the parts of both adults"* (A and B). A considerable part of the GP's records are as a consequence of notifications from other agencies professionals as opposed to any specific direct contact with the GP practice and the family or the respective adults. Adult A had 11 visits to the GP Practice in 8 years, which is not particularly significant and would appear to be well below the average expectations of a patient visiting his or her GP over such a timescale.

2.5.23 What Adults A's visits do highlight however is the fact that alcohol consumption featured significantly in the notes made within the medical records and that follow-up appointments were frequently offered in support of his health and well-being but were only very rarely attended by him.

2.5.24 In 2009, Adult A now 21yrs old was seen by a GP following his separation from his partner. He was referred to the crisis team, but he did not attend this appointment and this mirrors his reluctance to accept support following his earlier release from prison when 18yrs old in 2005 when he failed to attend his weekly appointments with his GP. This failure or refusal typifies not just his but moreover the overall family response to intervention support offered by a range of professionals.

[11] HM Government. 'Working together to Safeguard Children' 2013 is statutory guidance that all public services have to follow.

2.5.25 The Primary Care IMR also discloses that the family were *"well known"* to the GP practice and that this knowledge also involved the wider family unit and identified episodes of and references to mental health, self-harm, substance misuse and violence being regular occurrences. There was however no acknowledgement within the records of Adult A or B of any domestic violence being identified within their immediate family, although there was a record in 2010, where it was noted that Adult B had *"attacked her mother"* and was consequently recalled to prison.

2.5.26 Adult B's GP record by comparison is sparse up until 2011. However, it does highlight the good and accurate information sharing between the GP Practice and prisons during Adult B's periods of detention and re-calls to custody. The GP notes also refer to a *"chaotic family life"* and difficulties at school experienced by Adult B when 13yrs from 2003 onwards, but there is little evidence to suggest that she was seen by her GP in any significant medical perspective. In 2008, now an adult and 18yrs old, it was noted that she was *"keen to engage with community alcohol services".* Upon examination this was on referral from the Quick Access team and appears to have followed on from her arrest for assault and drunkenness - for which she shortly afterwards received a prison sentence, without actually engaging with any of the services offered to her.

2.5.27 In 2011, in notes indicating that Adult B 21yrs old had been discharged from prison some four days earlier, Adult B informs the GP at an appointment that she has been diagnosed with Bipolar disorder, however this was not confirmed. The GP made a follow-up appointment for her which she failed to attend. Three months later she attended the Practice and it is reported that she had signs of *"Mood destabilising"* and she was advised to re-start her medication, it is not apparent what this medication was.

2.5.28 Both Adults have criminal records, predominantly for offences of violence.

2.5.29 In examining the criminal background of both adults A&B the first recorded incident that Adult A came into contact with the Police was in 2003. This was for an offence of criminal damage and common assault. On conviction he was subject of a supervision order (by CDYOS) and a 'criminogenic' risk factor (ASSET)[12] assessment was made of him. At this time he was 'estranged' from his mother and her then partner and was living with his maternal grandmother. Amongst the key risk factors to him were noted as being his family relationships and his emotional health. It was noted that his mother had cancelled his health appointments for counselling that had been arranged in order to assist him in overcoming his father's death and his own attempts at suicide. It is highlighted in continuing assessment that he displayed *'temper issues'*. Shortly after being made subject to the supervision order he committed a further offence and was electronically managed (tagged) with a curfew and close supervision for a three month period. Although he engaged with the programme it is noted that the relationship with his grandmother broke down due to his deteriorating behaviour towards her and her home. Consequently he was given temporary

[12] A structured assessment tool on all young offenders who come into contact with the criminal justice system. It aims to look at the young person's offence or offences and identify a multitude of factors or circumstances ranging from a lack of educational attainment to mental health problems which may have contributed to such behaviour. The information gathered from Asset can be used to inform court reports so that appropriate intervention programme can be drawn up. It will also highlight any particular needs or difficulties the young person has, so that these may also be addressed. Asset will also help to measure changes in needs and risk of offending over time.

accommodation in the area in 2004 but shortly after this move he again returned to live with his mother and her partner.

2.5.30 It appears that he in effect 'bounced' between members of his immediate family when the relationships broke down and he had a continuation of disruptive living arrangements that perpetuated within his own intimate relationships as time progressed. The subject of what was or was not suitable accommodation never appears to have been effectively examined by any agency, although it was a frequent issue within the respective Adults lives.

2.5.31 In 2004 Adult A, then aged 16yrs, was sentenced for arson and burglary offences and was sent to a Young Offenders Institute (YOI). His sentence plan involved counselling, anger management and assessment for mental health issues. The plan appeared to have progressed well and integrated and engaged the mother and 'step-father' within the process. Adult A was recommended for early release but declined a mental health assessment on the grounds of that imminent release. The usefulness of the engagement was no doubt due to the fact that as an 'inmate' he had little choice but to integrate with the processes. This is replicated in later 'treatment' to Adult B as an 'inmate' in her later substantial prison term.

2.5.32 In 2004, Adult B then aged 15 years, was involved in a 'criminal' incident that occurred shortly before the release of Adult A from detention. It is perhaps significant that this occasion involved her arming herself with a knife and threatening her alleged attacker. The circumstances of the incident suggest that she had reacted to verbal abuse from a similarly aged male during a confrontation close to her home and ran into her house in order to arm herself with a weapon, picking up a knife from the kitchen. During the resulting scuffle the male received a slight injury whilst attempting to remove the weapon from her but was otherwise unharmed. The police were involved and after it was fully investigated no formal action was taken, due to the family not wanting any further action. However, the apparent lack of remorse and respect for both her parents and authority, led the attending police officers to submit a vulnerable child referral. It is already identified that following this referral, Adult B initially refused to engage with the worker and the mother advised that they were having problems with Adult B's behaviour and that she was drinking excessively, absconding from the family home in the middle of the night and smoking. Adult B claimed that she only drank when given alcohol by her mother and she was not absconding from the home.

2.5.33 A further referral was made for a Community Support worker to engage with Adult B, although there is no record of that engagement actually having taken place, which may be due to Adult B not wanting to engage.

2.5.34 Although it was expressed by the family that professional help was being sought for Adult B's anger management, this was not mentioned further.

2.5.35 Adult A was released in 2004 from detention and despite an *'appropriate response'* to the statutory supervision requirements as reported by the CDYOS, he failed to take up any non-statutory opportunities offered to him for any voluntary training programmes via Connexions. In December 2004 he appeared again before the Youth Court for public order offences and following the end of his supervised period, he appeared in court for an offence of violence.

2.5.36 The records from CDYOS indicate that throughout their supervision of Adult A it was noted that he, *"Lives a personal lifestyle, and within a family, where violence and aggression is normal".* This is an indication of the circumstances and the limited consideration of the perspective of the overall family unit, where the subject was dealt with over a period of time by professionals from a number of agencies as an individual as opposed to more needed incisive overall engagement and work with the family as a whole.

2.5.37 In 2005, a referral was received from school transport concerning Adult B where she had alleged that her step-father had physically abused her. A joint visit was made to the family home by Child Safeguarding services and the police in line with the then best practice. Adult B claimed that she had not spoken to the driver about any form of physical abuse but had instead talked to him about her taking vodka into school. Adult B did disclose at this time that her step father had actually slapped her [on her leg] but that it hadn't hurt. No bruises were seen on Adult B's legs, although no referral was made for a medical or paediatric examination. The case was closed with no further action being taken by either of the agencies.

2.5.38 In 2006, Adult B aged 15yrs returned home drunk and an argument ensued between her and her parents. The Police attended and having calmed Adult B down, removed her in order that she could spend the night at her uncle's home. She told officers that she did not want to return to the family home. Little is known of the uncle from any records examined by the overview author. As a result of this visit the police submitted a Juvenile concern form to their child abuse unit, there is no evidence of whether this was referred onto other agencies, as there is no record in any other agencies files.

2.5.39 In 2006 police officers were called to an address that she was frequenting and she was seen in a drunken state and also had a facial injury, it was unknown if this was as a result of being assaulted or as a consequence of her being drunk. Again officers submitted a Juvenile concern form and on this occasion Social Services were informed. Adult B was 16 years old at the time of both incidents.

2.5.40 In 2006, Adult B made an allegation to the police that she had been assaulted by her step-father on this occasion alleging that she had been pushed down the stairs by him. However she had no injuries. The step-father voluntarily left the home in order to alleviate the apparent tensions. Adult B was described as being aggressive both to the family and the police and she had been drinking. The fact that other family members had been drinking is again a consistent theme recorded by most of the practitioners who have been in contact with the family. The police referred this matter as a domestic violence incident and although no other action was taken, the response by the police was an effective intervention and acknowledgement of the circumstances, given the lack of co-operation by those family members present.

2.5.41 In 2006, Adult B was arrested for an offence of being Drunk and Disorderly (D & D). She was referred to CDYOS to assess her suitability to be made subject to a Final Warning as an alternative to a formal prosecution. This assessment task rested with a police officer who was seconded to the CDYOS. Adult B was assessed by the officer as being suitable for this diversionary action due to the minor nature of the offence and her age.

2.5.42 The assessment meeting took place at Adult B's home and she was considered as being suitable for a Final Warning to be issued and a programme of work with her was agreed. This programme, although required under statute, is actually voluntary on the part of Adult B. It was agreed that Adult B would undertake work on the consequences of her offending and referrals, for assessments and interventions, were made to the CDYOS nurse and the CDYOS Substance Misuse Worker. It was noted that Adult B's mother expressed concern at the number of professionals involved for, in her view, what was only a minor offence. A Final Warning was issued later in 2006 Having made the appropriate referrals a total of several further appointments, by CDYOS Police Officer, CDYOS Nurse, CDYOS Substance Misuse Worker, were offered to Adult B and her mother all of which they failed to be at home for. No further assessments were completed with them and the case was closed to CDYOS in 2007, although attempts at contact with them ceased in late 2006.

2.5.43 The CDYOS interaction with Adult A on the other hand was considerably more intensive, productive and co-ordinated; however this was in no doubt due to the fact that he was for a considerable period of the time of the engagement, serving a sentence within the HMP YOI. Following his release it appears that Adult A, although willing to cooperate with appointments offered to him he would frequently not accept offers of help, despite stating that the issues involved were of concern to him.

2.5.44 This is evident when in Castington Young Offenders Institute (YOI) where, in terms of literacy and numeracy and his general attitude Adult A made good progress although he did not want to be assessed by the Community Psychiatric Nurse. In addition, he did not take-up offers of counselling for the death of his father which he had also declined through his GP in earlier times.

2.5.45 In 2008, Adult B when aged 18 years, reported that her brother was drunk and was beating up his girlfriend. Upon police arrival Adult A's partner was standing at the window, with blood running down her arm and was intoxicated. The partner was abusive and aggressive to the attending officers. Adult A was as equally abusive and aggressive. Adult A and his partner made threats to the officers and also fought with each other. Adult A assaulted the attending officers and continued to make threats resulting in officers spraying incapacitant through the window. Once inside Adult A, Adult B & Adult A's partner were obstructive and all were arrested and later charged with criminal offences resulting from the incident.

2.5.46 Later, in 2008, Adult B was reported to having been bitten by Adults A's dog. Despite the allegation, it appears from the information the paramedics gave the police that this injury was inconsistent with a dog bite and was more likely to have been self-inflicted by a razor blade as it was described as being a deep and single laceration to her wrist. Although an ambulance and paramedics attended, Adult B was abusive both to the attending police and ambulance crews and declined further medical attention, or be clear on what had happened. Adult A was present at this time however he also was not forthcoming with any details concerning the incident.

2.5.47 In 2008 Adult B was sentenced to 12 weeks imprisonment for affray and assault on a police officer following on from the incident of early 2008. This was her first involvement with the Prison Service, however having served 9 days of her sentence before release, there is no information of any sentence planning or offending behaviour work. Given the length of sentence there was only a need for an assessment of her more immediate needs but no in depth assessment or intervention was possible in this short period of time. The short custodial sentence was rendered even shorter

because of the End of Custody Licence arrangements which the MOJ had in place at the time. She only served nine days because she was released under this scheme. She was released in 2008, and although having been sentenced for an offence of violence, she did not meet any Multi Agency Public Protection Arrangements (MAPPA)[13] criteria due to the length of sentence.

2.5.48 MAPPA, are a framework of statutory arrangements operated by criminal justice and social care agencies that seek to manage and reduce the risk presented by sexual and violent offenders in order that re-offending is reduced and the public are protected. This is done by the sharing of information and the establishment of coordinated risk management plans that allow offenders to be effectively managed. These violent offences do meet the offence criteria for MAPPA but the sentence length excluded the case from automatic MAPPA eligibility. The case could have been referred to the MAPPA Co-Ordinator as a Category 3 case, but this did not take place.

2.5.49 MAPPA criteria from MAPPA Guidance version 4.0 (2012) states:
Category 1: Registered sexual offender
Category 2: Murderer or an offender who has been convicted of an offence under schedule 15 of the Criminal Justice Act and;

- who has been sentenced to 12 months or more in custody or;
- who has been sentenced to 12 months or more in custody and is transferred to hospital under section 47/section 49 of the Mental Health Act (1983) or;
- who is detained in hospital under section 37 of the Mental Health Act (1983) with or without a restriction order under section 41 of that Act.

Category 3: Other dangerous offender

- a person who has been convicted for or convicted of an offence which indicates that he or she is capable of causing serious harm and which requires multi agency management. This might not be for an offence under Schedule 15 of the Criminal Justice Act (2003).

2.5.50 On the date of release she confirmed that she would be living at her mother's address, although later she indicated in an interview with the probation service that Adult A was also shortly to be released from prison [from the sentence arising from the same incident] and she asked for assistance in finding *'alternative accommodation'*. There is no record of this request actually taking place and in a further meeting with Probation noted in 2008, Adult B stated that, *'She and Adult A had fallen out over his relationship with his wife and he had moved out of mothers address',* indicating that they had both been living with their mother following his release from prison, which she had asked not to have happened.

2.5.51 In a follow up appointment with the Probation Service in 2008, Adult B stated that she thought that she might be schizophrenic. Although It appears that this may have been a passing comment no referral, for example to a CPN was made.

[13] The Criminal Justice Act 2003 ("CJA 2003") provides for the establishment of Multi-Agency Public Protection Arrangements ("MAPPA") in each of the 42 criminal justice areas in England and Wales. These are designed to protect the public, including previous victims of crime, from serious harm by sexual and violent offenders. They require the local criminal justice agencies and other bodies dealing with offenders to work together in partnership in dealing with these offenders.

2.5.52 A month later, in 2008, Adult B, who at that time was again now living with her maternal grandmother made references to having a *"strained relationship"* with her mother and Adult A. She was directed to a counselling service by probation service for her *'unresolved grief issues'* and advised to visit her GP for her sleeping problems. She did not visit her GP.

2.5.53 This was her final licence appointment and her actual licence period ended in 2008. The grief issues appear to be related to the death of her father now some 10 years earlier and appear to have remained unresolved.

2.5.54 Nine months later, in 2009, Police and Ambulance attended a report of a stabbing. The reporting call was actually made by Adult B, although she had fled the scene of the incident ahead of the attendance by the emergency services. An investigation established that Adult A had become involved in a fight with the eventual victim of the stabbing. As a consequence of witnessing this Adult B had gone into the kitchen and had taken a knife which she then used to repeatedly stab the victim about the head and neck in an apparent defence of Adult A. Although suffering serious and significant wounds the injuries inflicted on the victim were not life threatening. Adult B was intoxicated and left the scene, disposing of the weapon as she left. She was arrested by police officers nearby shortly afterwards and was charged with an offence of grievous bodily harm. Although not initially remanded in custody, she was remanded during the course of her trial.

2.5.55 In a pre-sentence report conducted by Probation in 2009 it was noted that this was a second offence where Adult B had defended and protected Adult A within an incident that involved excessive alcohol and *'thinking skills deficit'*. It also again highlighted the family using excessive alcohol. A comment within the reporting Probation IMR was that she was, *'Starting to show a pattern of violent alcohol related offending with potential disastrous consequences'.*

2.5.56 Adult A was convicted of common assault and was placed on a supervision order. Adult B was convicted of wounding with intent and received a 3 year custodial sentence in 2009. This was the second time that Adult B was imprisoned for an offence of violence that was in support of her brother. This was significantly more violent than the previous conviction against her. The trial Judge cited that she had used the weapon in a *"Potentially fatal way".* The severity of the sentence reflected the serious manner with which the Judge saw the attack, although he gave her credit for entering a guilty plea.

2.5.57 The HM Prison service commenced work with Adult B upon remand, pre-sentence. Adult B disclosed recent self-harm and she immediately entered the detox process as it was noted of her escalation in alcohol use since the last period in custody. A mental health assessment was made and although no specific concerns were raised, Adult B was referred to counselling and to obtain information concerning alcohol misuse.

2.5.58 A sentence planning board meeting in 2010, attended by Adult B, identified that she would be seen on a regular basis by an offender supervisor who would liaise with all parties involved and update the offender manager. In 2010 an Oasys [14] plan was set in place with an integrated approach, by internal prison departments to work with Adult B. During this process it was noted that the

[14] Offender assessment system, used in England and Wales by Her Majesty's Prison Service and the National Probation Service from 2002 to measure the risks and needs of criminal offenders under their supervision.

Offender Supervisor was to liaise with the head of Offender Management to discuss a possible IDRM.[15] Adult B was identified as being a MAPPA offender.

2.5.59 In 2010 a psychiatric assessment by a prison psychologist identified that Adult B had problems that were a combination of unresolved psychological trauma, personality difficulties, depression and possibly some psychotic symptoms. No actual diagnosis was made of a major psychotic illness and medication was agreed and arranged which comprised of Trazodone and Olanzapine. Both of these are recognised as treatments for severe anxiety and for their use as anti-psychotics.

2.5.60 Following on from this, Adult B was noted in a risk assessment for a home detention curfew (HDC) in 2010, that she was progressing well with her sentence plan and had shown remorse for the offence. She was noted as being on the mental health caseload and her key worker at the prison would refer her into the community if the assessment for HDC was successful. It is noted within the Prison IMR that the HDC board *'were encouraged by her willingness to change her lifestyle which included change of home circumstances in a new area'.* There is no information to clarify the extent of this as the release appeared to have been approved to her mother's address, which was not in fact a change of home circumstances.

2.5.61 In serving just over a year of her sentence, Adult B was released on licence in 2010. Her release was made on a Home Detention Curfew, meaning that she was electronically 'tagged'. Her risk assessment (to the victim of the offence or any other person at harm or risk from her) was as a 'Medium Risk'. She was released with an approved address location as being her mother's home. A home visit was made by the Probation Service the day following her release.

2.5.62 However two days after her release, Adult B had not only attempted to remove her electronic tagging device but was not at her release address when enquiries were made concerning that breach. As a consequence she was recalled to continue her prison sentence within a week of release.

2.5.63 Further assessments made in custody indicated that she had not taken medication during the period of release and had returned to drinking. She was further assessed by the psychiatric specialist in 2011, where it was reported that there were no symptoms or evidence of mental illness. In a review by the mental health team a month later, Adult B was reported as being compliant with her medication and no concerns of her mental health were expressed.

2.5.64 Adult B continued serving a custodial sentence for four months, when again she was conditionally released in 2011 on licence which again was to her mother's address.

2.5.65 The probation IMR comments that in the authors view this was suitable *'There were no convictions against Adult B involving violence towards family members, despite Adult A and Adult B mentioning violent arguments between them all'.*

2.5.66 Within two weeks of release, Adult B notified probation by telephone that she was now living with Adult A. The Probation Service noted and accepted that there was no concern with Adult

[15] Interdepartmental Risk Management meeting, where agencies such as the prison, psychology, education, security and often external agencies such as probation and social services, meet to discuss a specific offender, where there are issues of concern in terms of public protection.

B being at that new address as again this was an acceptable location for release purposes. The probation IMR comments that, *"There were no convictions by Adult A and Adult B towards each other, so this address was acceptable as family members. [The] co-accused would not normally be permitted to reside in the same household but as family members this would be difficult to enforce".* There does not appear to have been any home visit or verification check made in order to establish that the new address was in fact suitable, given that the address release was the actual approved residency agreement for Adult B's release on licence.

2.5.67 One month later Adult A accused Adult B of stealing from his home, which Adult B self-reported to her Probation Officer. She consequently returned to live at her mother's address. Adult A does not appear to have made any formal report concerning this allegation.

2.5.68 Later that month, Adult B reported to police that she had *'smashed up'* her parent's home and needed to be arrested. By this date Adult A had also returned to live at his mother's address but was not present at that time. When the police arrived, the mother was sweeping up broken glass and Adult B was described by the police as being intoxicated, but calm. It was suggested to the attending officers by the mother and Adult B that there was a *'misunderstanding'* between the two of them. However despite the best efforts of the officers the full facts could not be established due to the continued lack of co-operation on both the part of the mother and Adult B. Neither would elaborate. Although a domestic violence report was submitted the risk level of 'standard' was correctly applied and did not require sharing with other agencies and this level was endorsed by an independent supervisory review by the dedicated domestic abuse unit. The officers took appropriate action at the scene.

2.5.69 The Police are unable to ascertain that the officers carried out a Police National Computer (PNC) check on any of those present. Had they have done so, it *should* have identified that Adult B was on prison licence release. Although this is not a matter for the police to enforce, notification to the Parole officer (or Offender Manager) within the probation service could have led to Adult B being re-called to prison, as fits the MAPPA protocol.

2.5.70 A person can be recalled if: *They commit another crime or are charged with another crime or, they are behaving in a way that leads their Offender Manager to think they might be about to commit another crime.* For example, if they start drinking excessively and have previous convictions for using violence when they are drunk or, they break the conditions of their licence.

2.5.71 In this case it can be argued that the grounds for recall existed as it is apparent that Adult B was intoxicated and there was an implied indication of violence both to a person and to property and as such notification should have taken place to the Offender Manager in charge of her case at the Probation Service.

2.5.72 Later the following month, an anonymous call reported a disturbance in the street and on attendance officers discovered Adult B was having a domestic incident with her then partner. Both were described as being *'highly intoxicated and emotional'*. Police officers intervened by removing Adult B to her mother's address as neither party could be determined as being the aggressor. Although a domestic abuse referral was made by the attending officers, the grading as 'standard' again did not endorse circulation or referral outside of the police. It appears that Adult B was again on licence at this time and again no notification to the Probation Offender Manager took place. It is

noted however that the police report indicated that Adult B reported that she was suffering Bi-Polar[16] (however it should be noted that there has never been a formal diagnosis of this disorder).

2.5.73 Three months later, Adult A was reported by his mother, to be intoxicated and feared that he would commit damage to her home. Officers attended and Adult A, who had already left the address without apparent incident, was found intoxicated but compliant. Officers completed a domestic abuse referral appropriately as a 'standard' risk.

2.5.74 Two weeks later, a further report was made by the mother concerning the behaviour of Adult A. On attendance the officers discovered him intoxicated, but away from the address. He had a facial injury and was detained for being drunk. The mother refused to elaborate on the actual details above her initial report to the police.

2.5.75 It is clear judging by the incidents involving both Adult A and B, that in the weeks leading up to the fatal attack that alcohol misuse and episodes of sporadic violence continued to be the predominant features within the lives of both of them.

Section 3: Analysis

3.1 Family involvement and perspective

3.1.1 In making the analysis, the overview took the considered perspective that in order to contextualise, the views of the mother should be given primary consideration. Her disclosures are important when considering the wider picture and by comparison to the documented material available from the agencies. The overview is of course sympathetic to the situation that the mother and the family have to endure, however this has to be balanced against the facts known to the agencies which must be reported in an objective manner which the family may find upsetting. The overview author has not met with the family but is grateful to the Independent Chair of the panel in making the approach to and meeting the family with the assistance of the Durham Constabulary family liaison officer (FLO) from the originating murder investigation enquiry.

3.1.2 The mother of Adults A and B felt that they had a good relationship with each other and the circumstances of this tragic incident were completely unpredictable as she considered that they were so close *"like peas in a pod"* and had *"made a pact to look after each other"* after their father was murdered. This continued as they grew up in that they would look out for each other and remained protective of the other.

3.1.3 It was the mothers view that Adult B *"Went to prison (for A)"* as she had stabbed somebody in order to protect him. When questioned about whether or not the family believed that they had sufficient support from agencies that were in contact with them, the mother responded that they did not get sufficient support, however she elaborated by suggesting that they were, *"Brought up not to let things get to you"* and that all the support was *"within the family".*

[16] Individuals with bipolar disorder experience episodes of a frenzied state known as mania typically alternating with episodes of depression.

3.1.4 This perhaps indicates that the mother felt that, despite the offers of help from other agencies involved with the family, she was of the opinion that resolutions were not to be made outside of the family unit and this may be a reflection of the cultural upbringing where despite having problems, they did not want what they perceived to be outside interference. They considered that they were in control.

3.1.5 As a self-admitted alcoholic the mother was concerned that the she did not have enough support for her personal addiction or to support the family in coping with this throughout the childhood of Adults A and B. She stated that she was rarely in any fit state to look after them as she was frequently drunk and had been drinking for some 20 years.

3.1.6 In respect of health issues, the family believe that Adult B had mental health issues although this was not formally diagnosed until she was in prison on the first occasion. The mother claimed that she did not get sufficient help from doctors and struggled to get appointments. The overview report identifies however that this is contrary to what clinicians and other agency professionals are indicating and evidencing within their IMR's. Her belief that the children should have been provided with counselling following the death of their father is also an interesting perspective, given that the overview report would suggest that such opportunities do appear to have been offered on a number of different occasions but as such these were either declined or refused. There is also a clear indication in later assessments, for example the IMR from the Probation Service, which identifies Adult B's 'unresolved' trauma issues.

3.2 Analysis

3.2.1 In examining potential missed opportunities by practitioners the overview report identifies a number of occasions when interventions could have taken place or where events were perhaps handled too superficially. In 2003, a picture was emerging of two potentially troubled adolescents within a household. Both were potentially at risk of suffering significant harm.

3.2.2 In 2003, following the reported overdose of his mother's prescribed medication by Adult A aged 15yrs, the clinicians dealing with his admission, completed a child protection information form. Although this is good practice, there is no information on whether this information was shared or actioned when received by the Senior Nurse Child Protection in CDDFT. The circumstances of Adult A's presentation identified that he was excluded from school and had overdosed following a fight with his mother, which should have triggered a referral to social care based upon the presenting information. Four months later, Adult A, aged 15, presented at A & E and reported that he had been drinking bottles of beer. It was identified then that he had not attended for his psychiatric appointments made following his attendance in the earlier incident. This was not referred to the Senior Nurse Child Protection and consequently no other referrals were made, for example to social services. However, it is not possible to establish what actions were taken because the school records have been destroyed, in accordance with the national NHS Records Management Policy.

3.2.3 A further opportunity to share information concerning Adult A aged 16yrs was missed in late 2003, following his admission for an alleged assault, where he had been knocked unconscious. Little is known about the circumstances of this event and the CDDFT report indicates that no referral was

made to Social Care. As this was the third incident involving Adult A in a relatively short period, such information sharing would have potentially identified some emerging issues, in particular the wider family picture.

3.2.4 In the reported overdose by Adult B aged 14yrs, also in late 2003, just a few days after the last admission for Adult A at A& E, although the risk of harm from the event was in itself minimal, there was some important contextual information obtained concerning the family. The fact that the mother admitted to consuming an excessive consumption of alcohol, should have raised questions about her ability to provide safe parenting[17]. The fact that Adult B was identified as being her mother's carer, although acknowledged was not considered in any detail given her particularly young age. In effect by the end of 2003, there was some useful information concerning the family held, but not adequately shared. The opportunities for a joint agency intervention were present and this example indicates where such interventions should have been considered where no single agency could, or should be responsible for service delivery.

3.2.5 Another missed opportunity was the intervention by The Children's and Adults Safeguarding services in early 2004. In respect of Adult B in 2004, where the emphasis was focussed on her behaviour as opposed to the existence of facts that should have raised alarms and prompted appropriate management action and oversight. The appointment of an unqualified worker to a complex family was not a good management decision and the opportunities missed as a consequence included for example the failure to complete a core assessment; this could have been avoided if there had been adequate supervision of the worker. Significantly this would have brought other agencies to be involved and to have become actively consulted and become involved in the case. Health agencies and education services also played a key role in the identification of the pre-cursor issues. This lack of consultation is moreover a reflection of not using a multi-agency approach to look at the overall picture, and is not the fault of any one agency but identifies an overall lack of management oversight in general.

3.2.6 Other instances where a child safeguarding intervention was missed include in 2004 (Children's and Adults Safeguarding IMR) where it was alleged by Adult B aged 14yrs that she was only intoxicated when she was given alcohol by her mother. This visit was made in response to the referral made by the police concerning the first reported 'knife assault' on a third party. The fact that the child was alleging that she was in effect being given intoxicants was a serious allegation and potentially one of potential child abuse and neglect.

3.2.7 It appears that opportunities to have intervened and accessed the family in an informative manner were missed or overlooked during which was a critical time in the development of Adult B and also to Adult A who was not yet an adult. Bringing professionals together at this stage would have identified the fragility of the family and the children's vulnerability. At this time a number of agencies, including the CAMHS service, Children and Adults Services, Education and CDYOS could have and should have been in a position to have made an informed assessment of the family's needs. The family had been able to access services, but without any 'joining up' of the relevant issues by the services involved. If the family's needs had been put into context, and by asking the question of what happened 'then' and what happens 'now', the overview author is confident that

[17] Parents with alcohol problems have a degree of self-absorption in which their needs take precedence over the needs of the children. (Stephenson 2007) - Neglected children and their families.

services would now be much more likely to take action in accordance with the principles of Working Together which have incrementally changed in the decade that this review has looked at.

3.2.8 Adult B clearly had violent tendencies and had served an initial prison sentence for violence in 2008. In this incident she appears to have defended Adult A within the progression of the incident once the police attended. Although this didn't automatically trigger MAPPA considerations, it could have done if people had concerns. In the view of the author were there enough concerns to justify a referral.

3.2.9 However in 2009, she committed a much more violent attack, importantly that appears to be in defence of Adult A again. This attack could have led to a fatality and the sentence passed reflected what were the serious concerns of the presiding judge.

3.2.10 Adult B was released from this sentence for the GBH offence in 2010. She declined medication on release, indicating that she would consult with her GP. No mechanism was put in place to ensure that this perspective was supported, although the medical records from the prison healthcare were provided to the GP. Had the cross referencing to her record been examined it might have been noted that she had a history of poor attendance and follow-up and this emphasised Adult B's 'control' even at this point. A later confirmation check clarified that she had not attended her GP following release. Adult B was re-called some 6 days later following her almost immediate breaches of the conditions of her conditional release. This is good practice and shows the level of intervention to the conditions of her licence and the attention to detail by the Probation Service.

3.2.11 The question however arises at that point and also when she is released on her Automatic Conditional Release Licence some 4 months later, as to why she was not subject to a referral to the Offender Manager on the later occasions where incidents involving her occurred both at and near her home. Those incidents which should be seen as key opportunities to intervene and a lesson to be learnt from this review were:

(i) In 2011, in what was reported and referred to as a domestic violence incident with her mother.
(ii) Just a short number of weeks later when she was involved in a domestic incident in a public place with her partner and a number of other persons. This was also reported by the police as a domestic violence incident.
(iii) On neither occasion was she arrested, however this should not prevent appropriate communication of the facts and recall on occasions offers an immediate solution to prevention of further offending.

3.2.12 The Probation Service has the statutory responsibility for recommending the recall of an offender, however this relies on the throughput of information to them from agencies, for example (and not exclusively) such as the police.

3.2.13 The Prison report (referenced by the Probation Service IMR) suggested that Adult B could be managed safely in the community and that no referral to the MAPPA co-ordinator was deemed necessary either by the Prison or by Probation. The IMR of the Probation Service furthermore states that there was no other person identified as being at risk from her and that there was no MAPPA referral made by any of the other 'responsible agencies', including the police. The prison IMR confirms that only standard licence conditions were requested and that Adult B was given her

required reporting instructions at the time of her release. This licence release was due for expiry in 2012.

3.2.14 In examining the Probation and Prison IMR's respectively it is suggested that there was a '*sound system of communication between agencies most of the time'* referring to the time that Adult B was actually in custody. This does not appear to be the case once Adult B was released and the prison IMR further comments that *"given the involvement that Adult B had with the prison mental health team during the time in custody leading up to her home detention curfew (date) it was disappointing to note that that although a contribution was requested from the mental health team in relation to the prospective release of Adult B, no response was received from them"* There should have been a referral from the prison to mental health services on release from prison.

3.2.15 In this case there is just one occasion when Adult B met the criteria as a MAPPA offender, which was.

- In 2009 (sentencing occurred following an initial remand) when she was became a Category 2 level MAPPA (Violent offender by sentence having been sentenced to a term of imprisonment for 3 years for a relevant offence).
- In respect of her release on licence the Probation IMR indicates that "No referrals to MAPPA were deemed necessary by the Prison and Probation based on the risk of harm to the victim or anybody else" and in addition that there were no MAPPA referrals from any other agency.
- It is however unlikely that there would have been any other 'interested parties' at that time, given that Adult B had served in excess of a year of her sentence. In this case she was released as a Level 1 MAPPA and her risk category on release was classified as medium to *"known adult and staff".*
- Adult B was initially released on licence in 2010, however having breached the terms of her licence she was re-called to continue her sentence six days later and was then further released on licence after four months to her mother's address with an additional comment made that there were *"No convictions against Adult B towards family members".*

3.2.16 The concerns expressed in this case are that there appears to have been little multi-agency acknowledgement of the background of domestic abuse (other than police as a single agency) that was present within the family. The current Home Office definition of Domestic Abuse is *'Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality*' In examining the circumstances where domestic abuse was present which fits this definition and the past definitions of domestic abuse that agencies were working to at the time, there were numerous instances that involved for example:

- All Adults against the mother
- Adults A and B against respective partners
- Siblings (All Adults) against sibling
- Background of domestic abuse involving the maternal grandmother

3.2.17 None of this information, despite being available in professional practice appears to have reached MAPPA, despite the agencies duty to co-operate with the responsible agency. The question

that arises here is where the lines of communication present, or indeed fully understood by professionals.

3.2.18 MARAC is a Multi-Agency Risk Assessment Conference, aimed at preventing and reducing domestic abuse. There is in this case no obvious suggestion that any of the family members should have been discussed at MARAC. Had there been repeated instances involving a particular member of the family, this may have been a consideration, however in analysis because the actual victim within the family fluctuated on almost each occasion of domestic abuse this led to the family being kept under the radar.

Section 4: Conclusions and Recommendations

4.1 Conclusions

4.1.1 The overview author fully accepts that this family had difficulties and were hard to engage. They do not appear in principle to be a 'hard to reach' family, yet barriers and hurdles were placed in the way of professionals from all agencies by the family. It is possible that a more dynamic and inquisitive approach by professionals could have made an impact and where working in closer partnership approaches could have been considered. The disclosure of specific facts is of concern when looking more holistically at how and when opportunities to look deeper into the family issues *could* have been undertaken but were not carried out. These are not considered by the overview author as systemic failures, but really frequently missed opportunities where more questions should have been asked by practitioners, managers and supervisors. The frequent lack of incisive review and being professionally more inquisitive and questioning and also challenging staff, is the reasoning for this observation.

4.1.2 The early efforts to intervene into the family were met with little apparent response from the family in general, particularly the mother of Adults A&B. It appears that the mother engaged when she felt that the circumstances necessitated or it was prudent to do so, but she did not appear to as evidenced in the IMR's always welcome professionals into the family. On occasions it appears that by her reactive approach to dealing with occurrences involving Adults A or B, she sought intervention as an immediate response to a given problem.

4.1.3 Although acknowledging that the family closed opportunities for intervention, it is also fair to conclude that a number of agencies also did not go further in their efforts to intervene and support the family. Where the head of the family displays overt negativity on multiple occasions it should have the effect of creating far greater curiosity on the part of professionals and where more questions needed to be asked within that agency and also a multi-agency response.

4.1.4 Looking initially at Adult A the following comment in the report from the CDYOS made in 2004 that he, *"Lives a personal lifestyle, and within a family, where violence and aggression is normal".* This is perhaps an insight to the overall picture of the family unit and where they have been dealt with as an individual as opposed to a more incisive and overall engagement in order to work with the family as a whole. By this time, there was a significant level of information held by all agencies

that taken with the views of those comments, where if they worked in partnership could have had a profound effect on service provision and intervention opportunities to have worked with the family as a whole. This relies on adequate information sharing.

4.1.5 On a number of other occasions where the police were involved in attending incidents where there were episodes of violence and disturbance involving invariably one or more members of the immediate family, drunkenness or the apparent excessive consumption of alcohol and or other intoxicants were frequently the significant presenting factor. The question again arises as to how such episodes should be dealt with as the misuse of alcohol is far from being unique to this case. Working with individuals with chronic dependencies who are neither motivated nor resourceful requires incisive intervention, which needs to be co-ordinated.

4.1.6 Police officers are regarded as experts in offences of drunkenness and health professionals frequently find themselves encountering the aftermath of excessive alcohol consumption. Consequently the police and healthcare professionals often are by the very nature of their work best placed to not only identify the symptoms but are frequently in a position to identify and assist in signposting individuals for independent support. On occasion's positive intervention may be of more value to the individual by referring them for support rather than to prosecute which in reality only goes as far as to deal with the effects rather than the symptoms. Although acknowledging that it is highly unlikely that Adult's A&B or the mother would have self-referred, a question that could be asked is do organisations within County Durham offer enough opportunities and encouragement for people to self-refer on top of the agencies own professional and statutory capabilities? If the answer to this question is no it should be marketed that the Community Alcohol Service within County Durham includes self-referral and has open access clinics throughout the county.

There is some good work noted and some examples of service development commissioned by Public Health within County Durham which is outlined below, but the overview report suggests that there is more work still to be done, though acknowledging that you can't force someone into alcohol treatment:

- A dedicated Community Alcohol Service was established in 2009 across County Durham. All staff are trained in dealing with domestic abuse and there is a referral pathway between the alcohol service and domestic abuse service. The risk assessment paperwork identifies victims of domestic abuse as higher risk/vulnerable client group and the criteria to access the service is lower than for the general population given this risk. In this case alcohol was a critical factor so this is seen as very positive.

- The Community Alcohol Service accepts self-referrals and have open access clinics within the county 5 days a week.

- Work is underway to explore the feasibility of establishing a 7 day week or on call arrangement over a weekend period, although accepting it will still need engagement and consent from the individual.

- Alcohol screening and referral to the alcohol service is underway within a custody setting. This is important when working with perpetrators. This activity will require evaluation and

the subsequent referral to Community Alcohol Services to ensure the screening is achieving the impact that was envisaged.

4.1.7 The overview report suggests that relatively little was known about the actual family dynamics however clear warning signals existed throughout agencies engagement with them from early 2003 which should have been acted upon. For example, both Adults A and B effectively moved between their mother and grandmother's homes, yet the reasons for the respective moves between the addresses was not known. There is no evidence within all of the IMRs of recognition of Adult A & B's voices being heard when they were children however it must be noted that there is not any evidence that appropriate safeguarding considerations were not taken, which this overview report suggests could have been.

4.1.8 Although this extends to an extent beyond the dates of the terms of reference, it is important to contextualise given that a number of the IMRs authors have identified such matters. The overview report recognises that the following comments should therefore be made in considering the wider picture.

4.1.9 There is clear evidence that clinicians; in particular health professionals, were aware of the significance that the death of the father had in particular in respect of Adult A and some effort was initially made to offer appropriate support through counselling. The relatively young age of Adult A made him suitable for support although it is of course difficult to say what affect that this would have had [if any] on him and his future development. Although it is unable to be said with certainty due to the school records for Adult A & B being destroyed. (It is felt that education could have worked together with health professionals to have made a difference by examining the potential root causes to his disruptive behaviour and sporadic school attendance, albeit this cannot be confirmed due to the lack of records to be examined). A letter from a Consultant Paediatrician to Education SEN and copied into GP practice concerning special educational needs identified that Adult A had *"significant behavioural problems and learning difficulties exacerbated by lack of regular education*". It shows again that matters were treated in apparent isolation as opposed to a holistic approach.

4.1.10 Adult B would also have had similar issues of bereavement and loss following the violent death of her father. She has grown up with a parent who has misused alcohol and there have been family incidents that have included violence and as such should have been identified as being domestic abuse. On a number of occasions the police recognised the signs and symptoms of such domestic abuse, however the standards of reporting which quite rightly fits as 'standard risk' did not trigger automatic referral outside of the force. Another question is should the County Durham partners follow the leads of similar forces and provide a Multi-agency safeguarding hub (MASH); where the co-location of a range of suitably trained professionals serves to enhance overall public protection. The overview author fully acknowledges the great progress already made in County Durham through the police led central referral unit, but believes it should go further given the success of similar units across the country, and is included below as a recommendation.

4.1.11 Adult B's case was open to Children's Safeguarding Services from 2003 following two referrals, one from Education and another from CAHMS. Both referrals suggest that Adult B was a vulnerable young person whose presentation had deteriorated and that she had recently been hospitalised following an overdose by taking her mother's anti-depressants. A regular visiting

pattern followed for a further 12 months which also included transportation for mother and Adult B to CAHMS appointments.

4.1.12 The initial assessment having been completed by an unqualified social worker led to no further assessment being undertaken including any risk assessment around the family's alleged propensity for violence. The initial assessment had incorrect dates on it and it was never formally closed by the agency. There was no management oversight on the assessment and although the case notes suggests that there was regular communication between the agencies involved with Adult B there was only one meeting actually recorded. There was minimal management oversight and guidance around the continuing case. The case was formally closed in 2006 however the last case note was made in late2005.

4.1.13 No links were made to sibling's workers or parent's workers. There is only one referral after the case was closed from a hospital doctor concerning a safeguarding issue. There is no link to any adult services involved with mother, mother's partner or sibling of Adult A and Adult B. In effect practical actions and solutions appear to have been the main focus of the care planning. Evidence of violence should have given rise to the wider consideration of child protection, domestic abuse and consequently looking holistically at the symptoms and causes as opposed to what was overall a superficial response to the needs of Adult B. These are examples of where there could have been a more joined up approach. The review does accept that the approach to working together and Think Family has in more recent years, moved ahead significantly. Within County Durham they run the equivalent of this scheme, which they call 'High Impact Households' The definition (2012) of which families qualify as one of these households, would seem to fit perfectly the household of Adult's A & B and it is believed that this family would have been on this scheme and it is hoped that this would have made a difference. The definition is:

'Those families that have a disproportionate impact on communities, children, families or partner agencies resources, as either perpetrators or victims of crime or anti-social behaviour. They tend to experience complex health, social economic and behavioural problems which pass from generation to generation despite extensive and prolonged interventions from a range of agencies. Typically the family will have either failed to engage with services or demonstrated low motivation to engage'

4.1.14 In looking in particular at the Children and Adults Safeguarding contact [chronology] with Adults A and B, during the whole of 2004 it was extensive and perhaps exemplifies the significant opportunities that were missed in looking at a multi-agency approach to the family where much more could have been learned about them all.

4.1.15 The safeguarding process should be a primary consideration and in examining the Children and Adults IMR and chronology there are frequent references to the home conditions that appear to have typified the environment in which both adults were being brought up in.

4.1.16 Would such issues be noted in the current partnership approach now is another question to pose. However these matters should be taken into context and putting current standards of assessment, care and consultation the overview author is of the considered view that a repeat of what was at that time poor communication between agencies and decision making when looking at wider issues would be unlikely to happen now. What this overview report does identify is the continuing necessity for adequately trained practitioners to manage or at the very least quality

assure untrained or trainee professionals' work to ensure that it meets both local and statutory requirements. Management oversight is a critical element to 'thinking clearly' when looking for interventions and solutions.

4.1.17 Predicting whether or not this homicide was likely to occur, and thereby be prevented, is a matter for debate. There was nothing overtly apparent to any of the agencies within the respective IMR's or from the family that gave any immediate indication of Adult B's propensity for violence against her brother and in fact the opposite as there is evidence that she often was very protective of him. It is the overview author's view that this homicide could not have been predicted and thereby not prevented.

4.1.18 The overview report does however identify that there was a progression of the levels of violence used by Adult B as she moved into adulthood although predicting homicide is not obviously apparent from the information available, other than her apparent intentions in the time immediately preceding the homicide, there is no doubt that her violent behaviour appeared to be escalating.

4.1.19 The overview also acknowledges the contextual and process changes made since 2003 in particular that of safeguarding and the development of practise concerning domestic abuse, is considerably different to that which was available in 2003. There is little doubt that the instances seen herein would be unlikely to be repeated by applying current standards of reporting both within an agency and in partnerships.

4.2 Recommendations

4.2.1 The overview author acknowledges the distress that this tragic death has had on the family and fully appreciates the family's observation that they have in effect lost two people as a consequence of this tragic incident. The overview author has made every effort to make sure that the comments made are factual, balanced and take into account both context and practice at the relevant time. It also acknowledges that the family may be upset by some of the issues as raised but it is important that they are able to understand the support offered. This is important for practitioners to understand so as to be consistent and where necessary persistent in their efforts to offer support.

4.2.2 The conclusions reached are fair and balanced taking into account the relevant issues at the time and this review does not apportion blame, but seeks to understand where services were missing coordination and how this can be taken forward. This overview report will be shared with Durham's Children and Adult Safeguarding Boards for them to ensure relevant issues and learning are taken forward by each of them.

4.2.3 The domestic abuse within the family, although identified and recognised by professionals was not holistically examined when it was encountered. The overview author recognises that the knowledge and dynamics of identifying and tackling domestic abuse has moved forward and it does not propose to explore what could perhaps have been more thoroughly evaluated at the time. However had this been so, the opportunities to have worked more closely with the family may have 'broken down' the communication barriers that were present. Care must be exercised to ensure that

the purpose of ensuring that 'boxes are ticked' is not simply that and that supervision and management oversight are able to look more closely at domestic abuse referrals to ensure that deeper issues are not overlooked. There can be no superficial approach made to dealing with domestic abuse, it requires evaluation and the amended domestic abuse definition now in use should be robustly applied by all those who have a duty to identify and safeguard the vulnerable.

4.2.4 To that extent there should be continued professional development made available to professionals through experts and practitioners. The wealth of knowledge and experience available within agencies, in particular the police public protection teams and independent advocates, should be utilised in supporting professional development across agencies. For example the training of GP's, primary care staff and other health professionals. Tackling domestic abuse continues to be a priority for professionals and the training and development of practitioner's knowledge base appears to vary across the Country. The overview report comments that this is not the first occasion that gaps, in particular, in the training of a range of health and also other agencies professionals concerning domestic abuse, have been noted across the country, and it is important for the SDPB to acknowledge lessons from other DHRs. There is scope for the local clinical commissioning groups and NHS England area team to commission work with the police and other key stakeholders, in continued training in the identification of abuse.

There were a number of occasions where professionals in a number of agencies missed opportunities to ascertain a more informed background of the family unit and this fundamental lack of detail did not assist in decisions made. For example whether or not the family home was a suitable environment for Adults A& B to remain in as a range of issues ranging from child protection, neglect, domestic violence and anti-social behaviour, were frequently observed, over a number of years. There were constant changes in the home environment that received comment in records, but without any significant detail and where up to date information to professionals was imperative in order assist in their decision making processes. Professional curiosity must prevail throughout and this must extend to management oversight of their staffs work.

Recommendation 1: An integrated multi-agency domestic abuse and sexual violence training plan is currently in development. This needs to identify the resources across the partnership to implement this plan including those sessions delivered by Harbour the commissioned Domestic Abuse Outreach Service. The plan needs to identify priority groups of staff for training and ensure a rolling programme is implemented. All training should emphasise the contributory factor of alcohol on domestic abuse as well the need for 'professional curiosity' and 'respectful uncertainty' rather than professional optimism.

4.2.5 Several Police forces have 'leaflet packs' available for persons arrested for alcohol related offences. This is in place within County Durham and is a subtle intervention opportunity and although the take up response cannot be qualified this is a good vantage point for intervention services to become involved and to encourage individuals to make self-referral. What is the current impact of this service? Alcohol screening in a criminal justice setting has shown to be effective, however further work to assess the impact of alcohol screening by custody staff is underway.

Recommendation 2: There is currently an initiative in custody suites where each individual identified in an alcohol related incident is subject to screening. The Alcohol Harm Reduction Group to evaluate the effectiveness of the current initiative, in custody suites in County Durham.

4.2.6 Durham Constabulary has a Central Referral Unit which also has multi-agency partners within it; some of the partners would like to consider setting up a Durham partnership CRU. The processes that a MASH utilises in relation to information sharing and a result of this safeguarding both children and adults, is nationally regarded as good practice and has been highlighted in a number of National and Governmental reviews as best practice. The development of the CRU would really strengthen the partnership information sharing. MASH was designed and developed to create an environment where all statutory and non-statutory safeguarding partners are embedded together in an integrated workplace in order to deliver partnership assessment and decision making in relation to concerns about both children and vulnerable adults. MASH is designed to create the confidence and trust amongst all professions and partners to share both confidential and non-confidential information and intelligence in order that the best possible decisions concerning interventions or support can be made. MASH is designed to deliver three specific outcomes, in relation to robust information sharing;

- **Early identification and understanding of risk** – *Earlier and better decisions based on full partnership information picture*
- **Victim identification and intervention** *- the identification of unseen victims, the recognition of multiple notifications of concern falling below thresholds and the earliest identification of harm and risk to drive earliest interventions and support*
- **Strategic harm identification and reduction** – *Analysis and research across the rich partnership data within a MASH to identify the harm of today and tomorrow. Enables targeted intervention and support for best outcomes and the business case for commissioning of services against a true picture of harm*

The Durham Constabulary CRU is progressing really well, but still lacks a permanent health presence within. In the case of Adult's A & B and their mother the information that could have been shared through the MASH and if the information was shared in the MASH then risk assessed it would have been of a real benefit in keeping her and her children's life safer from harm. In this case and in many others it would have been of real tangible benefit to have a relevantly experienced health professionals linking into the MASH.

Recommendation 3 Consideration is given to continuing the development of the Central Referral Unit with it becoming a fully functioning partnership CRU or Multi-Agency Safeguarding Hub (MASH) The priority maybe to first consider this for children then move to incorporate adults.

4.2.7 The release of offenders on licence from a custodial sentence is a regular occurrence and on occasions such licence conditions are breached in the early stages of that release. The National Probation Service[18] (NPS) which will replace the current Probation Service Trust's, will continue to be

[18] Under radical changes to probation set out in May 2013 the NPS, working alongside a range of private and voluntary sector organisations will replace the existing Probation Trusts and have overall responsibility for public protection, building upon the expertise and professionalism of the existing 35 Trusts.

The NPS will also be charged with ensuring tough action is taken where lower level offenders breach the terms of their licence or community order, including missing appointments, refusing to engage with their rehabilitation or slipping back into drugs and alcohol abuse.

responsible for the management of offenders released early from their sentence in company with community rehabilitation companies depending on risk of harm, all of the high risk will sit with NPS. They will be responsible for re-call where it deems it is in the interests of protecting the public. It is important that appropriate lines of communication continue to exist in particular between the police and the NPS. In this case there were two occasions when, it would appear, that the police did not alert the Probation Services Offender Manager of the circumstances of the contact with Adult B when she was 'on licence'. Both instances related to breaches of the conditions. There were instances where violence including what was a domestic violence incident between Adult B and her mother, where alcohol consumption was an apparent aggravating factor. Such occurrences should be reported and acted upon accordingly if the safety of the public is to be maintained. A MAPPA meeting could have taken place which would have had the benefit of bringing together agencies to jointly share and discuss risk this might have made a difference with a more holistic and cohesive view. It is fair to state that on the occasion of recall to Adult B in 2010 that this was dealt with in a swift and effective manner, but this relied upon an effective notification process that was triggered by electronic data as opposed to agency dialogue.

4.2.8 The Durham and Tees Valley Probation Trust IMR makes no actual internal recommendations, however in paragraphs 4.1.4 and 4.1.5 of that report, it makes reference to improvements previously sought in respect of *"self-reporting" and "home visits".* The critical point to consider here however is that the areas identified within the probation IMR are of relevance to the bigger picture and it is important for example, to understand what is meant by *"the over reliance of self-reporting"* and how this perspective could affect other agencies action or activity. This requires clarification.

Recommendation 4: A) Durham Constabulary reviews its processes in relation to any breaches of licence to ensure that they are referred to the probation service.

B) That other professionals and agencies (where they are aware that NPS are involved) that have a relevant duty to ensure that information sharing protocols with the Probation Service [NPS] are robust and lines of communication are clear. The Probation Service [NPS] should be notified of any potential licence breach at the earliest opportunity.

C) The MAPPA Strategic Management Board to consider having within its management plan the setting of a thresholds policy for referring cases into MAPPA.

4.2.9 The second area of improvement was the need to undertake home visits. The IMR comments *"Another area for improvement was the need to undertake home visits, during supervision, where the offender is presenting as chaotic and there are concerns about safeguarding of children or domestic violence".* In this overview report, the fact that home visits by a number of agencies identified poor living conditions and also a background of potential domestic abuse in the lifestyle of the family, this makes such a statement a key factor and therefore this area for improvement should be carried forward under this DHR process as an action so that practitioners are fully aware of the need to have both professional curiosity and not to be over optimistic that families are able to without help to improve their situation.

4.2.10 A comment contained within the Children's and Adults Safeguarding IMR perhaps sums up the observations made in this overview report.

"This family could have been subject to more intensive support, not just Adult B, but the mother, step-father and siblings"[19]

4.2.11 A frequent and recurring failure or refusal to attend appointments was a common thread within the family. In the majority of cases this was for healthcare appointments however there were a number of other occasions where the family failed to be at home for key visits, as exemplified in the IMR of the CDYOS. On most occasions this failure by the family did not trigger any significant follow-up action and the 'did not attend' information was not specifically identified or shared between agencies. Such occurrences could be of importance in other agencies knowledge base and a mechanism of local notification to key agencies should be maintained for the purposes of assessment and joint intervention opportunities. In effect this would act as an 'information and intelligence' process.

Recommendation 5: The Safe Durham Partnership recommends that health providers in County Durham review their DNA policy and make sure that it is being appropriately applied. Health practitioners should be encouraged to identify those high impact families who persistently fail to attend and share this information with the referral agency as 'did not attend' (DNA) as part of this DNA protocol.

4.2.12 The overview identifies that the IMR from Durham County Council – Children and Adult Services (Education) lacks significant information concerning the adults and their educational background, although it is indicated that both were excluded from school in their early teens. The mother of the Adults claimed that they were home tutored, however there is no information to verify the provenance of this claim.

4.2.13 Education has a significant role to play in the identification of early warning of problems within families and in this case the IMR from the Children's and Adults Safeguarding, responded to the concerns raised by the school attended by Adult B at that time. The education records do not replicate this information as it transpires that relevant records concerning Adult B were destroyed.

4.2.14 Taken in context, the overview author acknowledges that the parameters of the DHR would have excluded much of the early educational information however the agency should review its policy on destruction of files to ensure that it is robust and fit for purpose.

Recommendation 6: Durham County Council, Children and Adults Services (Education) reviews its policy and issues best practice guidance for schools concerning the ethical and statutory retention of files for those pupils that are from vulnerable groups in particular those excluded.

[19] *Think Family: Improving the Life Chances of Families at Risk, – Department of Children, School and Families. 2008*

4.3 Good Practice identified

4.3.1 The overview report would like to point out that although there is a need for improvement that contextually the manner with which problem families, as in this case, have been dealt with has changed in more recent years within partnership interventions. It is not the preserve or indeed the responsibility of a single agency to resolve and although case conferences and other forums offer opportunities for greater joined up approach, each case must be regarded on its own merits or support becomes a menu based approach rather than a bespoke and needs based intervention.

4.3.2 There have been a number of occasions of good practice identified within this DHR that the respective agencies should take forward.

4.3.3 The overview report comments on the good practice of the sharing of the medical records and overall communication between the HM Prison service and the GP practice concerning in particular Adult B, but also Adult A. The timing of the release of the records was efficient and effective and the records as such provided the GP practice with accurate and up to date medical records.

4.3.4 There was good communication with the electronic monitoring company (who have not been consulted within this review process) and the Probation Service, who, in 2010, were able to make an immediate and informative judgement concerning the recall of Adult B's conditional licence. In comment, this should act as 'business as usual' and as indicated, acknowledged and actioned accordingly by other agencies who have the duty to preserve public protection.

4.3.5 There was good identification by the police, on a number of occasions, of the domestic abuse within the household, in particular that between the mother and the respective Adults. This does place the police in a position of expertise in making informed decisions, but also identifies the benefits in using this knowledge base in supporting other professional practice and moving this information into other agencies remit.