

Aylesbury Vale Community Safety Partnership

Executive Summary

Domestic Homicide Review following the death of
Keith, who died in January 2017

Domestic Homicide Chair and Author: Gillian Stimpson, Lime
Green Consultancy Services Ltd.

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1. THE REVIEW PROCESS

This summary outlines the process undertaken by Aylesbury Vale Community Safety Partnership Domestic Homicide Review Panel in reviewing the homicide of Keith, who was a resident in their area.

The following pseudonyms have been used in this review for the victim and perpetrator and other parties to protect their identities and those of their family members:

Keith, the victim, was born in England and was aged 26 at the time of the fatal incident.

Kye, who was found not guilty of Keith's murder, was born in England and was aged 18 at the time of the fatal incident. Keith and Kye were brothers but did not share the same father.

The child, refers to the child born to Kye and Gemma

Coralin is the mother of Keith and Kye.

Gemma is a previous partner of Kye and the mother of their child.

Chantal is the current girlfriend of Kye

Eme is the girlfriend of Keith.

Kane is the twin brother of Kye - has no direct links with the homicide incident.

Tom is an ex-partner of Coralin

Criminal proceedings were completed on 19th June 2017 and the perpetrator was acquitted of one charge of murder.

The process began with an initial meeting of the Community Safety Partnership on 20th January 2017, when the decision to hold a domestic homicide review was agreed. All agencies that potentially had contact with the victim and alleged perpetrator prior to the point of death were contacted and asked to confirm whether they had involvement with them.

15 of the 20 agencies contacted confirmed contact with the victim and/or perpetrator and children involved and were asked to secure their files.

2. CONTRIBUTORS TO THE REVIEW

The following agencies and contributors were involved in the review:

The Panel spoke in person with Coralin and Kye – mother and brother of Keith. Kye was arrested following the death of Keith.

A telephone conversation took place with Eme, Keith's girlfriend

A friend of Keith's spoke briefly with the Chair in person

Thames Valley Police (TVP) provided a chronology and an IMR

Buckinghamshire Healthcare (NHS) Trust (BHT) provided an IMR for their involvement with Keith.

South Central Ambulance Service (SCAS) provided an IMR which included a chronology

Buckinghamshire County Council (BCC) Children's Services provided brief information in respect to the child of Kye and Gemma.

Clinical Commissioning Group for Aylesbury (AVCCG) provided an IMR completed by a Dr. in respect to the brothers, but Kye had no contact with a GP surgery during the review period.

Victim Support (VS) provided a short summary of involvement, but this was in respect of unrelated incidents involving the family.

A series of questions were responded to by YMCA in respect to a period when Keith was living at the hostel in Wycombe.

SMART – drug treatment service provided a chronology and IMR.

Connection Support provided an IMR in respect to their engagement with Keith.

Aylesbury Homeless Action Group (AHAG) had been working with Keith and provided an IMR.

Aylesbury Women's Aid (AWA) provided an IMR.

Oxford Health provided a statement of Fact in respect to Kye. Keith was not known to the service.

Aylesbury Youth Concern provided a summary of contact and the Chair met with the Service at their request.

2 schools in provided a short report on the periods that Kye attended these schools. These periods are outside the scope of the report.

Home Group – Stonham Housing provided a short statement in respect to their knowledge of and involvement with Keith.

The subjects of the Review were not known to any other services.

All the information and reports provided were given by staff who were not involved with the subjects of the review or have any direct management of staff who had previous links with the subjects.

3. THE REVIEW PANEL MEMBERS

The Domestic Homicide Review Panel consisted of the following members, all of whom had no engagement with the subjects of the review:

Independent Chair of Panel, Gillian Stimpson, Director, Lime Green Consultancy Service Ltd.

Thames Valley Police, Acting Detective Inspector Tracey Benham (2 Meetings),

Buckinghamshire County Council, Julie Puddehatt, Head of Safeguarding Adults and Deprivation of Liberty Safeguards (3 Meetings)

Aylesbury Vale District Council, Will Rysdale, Assistant Director, Community and Fulfilment (3 meetings)

Aylesbury Vale District Council, Chris Oliver, Community Safety Advisor (3 Meetings)

South Central Ambulance NHS Foundation Trust, Tony Heselton, Head of Safeguarding (2 Meetings)

Thames Valley Probation Service, Charlie Walls, Senior Probation Officer (1 Meetings), James Lynch, Senior Probation Officer (1 meeting)

Aylesbury Women's Aid, Denise Edmunds (0 Meetings – apologies received for first meeting and did not attend the 2nd meeting)

Buckinghamshire Healthcare Trust, Karen Sobey-Hudson, Head of Patient Safety & Litigation (1 Meeting, but closely involved at review stage by virtual correspondence)

Aylesbury Clinical Commissioning Group, Victoria Gray (1 Meeting – Victoria moved to a new job after the first meeting) and Dr Lesley Ray, (2 Meetings) Safeguarding Managers

SMART – Lisa Harrison attended the first meeting with Stewart Balmer (2 Meetings)

The Panel met on 3 occasions and had numerous engagements through email and telephone conversations.

4. AUTHOR OF THE OVERVIEW REPORT

The Domestic Homicide Review has been chaired by Gillian Stimpson of Lime Green Consultancy Service Ltd. Gillian has been the Director of the Company since 2015 and has been undertaking Domestic Homicide Reviews and chaired two Serious Case Reviews, one for a baby death and one into child sexual exploitation.

Gillian has had previous experience as a Police Officer in the Metropolitan Police from 1978 to 1987 and as Community Safety Manager for Wycombe District Council, from 1993 to June 2015. Gillian currently has no connection to the Aylesbury Vale Community Safety Partnership other than in the undertaking of the Domestic Homicide Review.

In 2013 Gillian successfully undertook the Domestic Homicide Chair Certificate, a Home Office funded 5-day training course delivered by AVA (Against Violence and Abuse) accredited by the Open College Network (OCN). Gillian continues to undertake professional development and has attended a day's training on the new Domestic Homicide Review Guidance.

5. TERMS OF REFERENCE FOR THE REVIEW

The purpose of a DHR is to:

- a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- b) identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
- d) prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
- e) contribute to a better understanding of the nature of domestic violence and abuse; and
- f) highlight good practice.

The Review will cover a period of 1 year prior to the homicide but those participating in the Review are to consider contacts and engagement with the victim and perpetrator prior to this and if there is information that would be relevant to the review, that should also be included.

Review Process and Considerations

As part of this Review Process the Domestic Homicide Review Panel considered a number of areas, which have been covered in the report including the following:

- a. What appear to be the most important issues to address in identifying the learning from this specific homicide? How can the relevant information best be obtained and analysed?
- b. Which agencies and professionals should be asked to submit reports or otherwise contribute to the review including, where appropriate, agencies that have not come into contact with the victim or perpetrator but might have been expected to do so?
- c. Did the victim have any contact with a domestic violence and abuse organisation, charity or helpline? How will they be involved and contribute to the process? Helplines, charities and local specialist domestic abuse services, including refuges, can be a useful source of information, although the disclosure of information about perpetrators may be subject to legal considerations.
- d. How should family members, friends and other support networks (for example, co-workers and employers, neighbours etc) and, where appropriate, the perpetrator contribute to the review (including influencing the terms of reference), and who should be responsible for facilitating their involvement? How will they be involved and contribute throughout the overall process taking account of possible conflicting views within the family?
- e. How should matters concerning family and friends, the public and media be managed before, during and after the review, and who should take responsibility for this?
- f. Consideration should also be given to whether either the victim or the perpetrator was an 'Adult at Risk' – a person "who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of himself or herself, or unable to protect him or herself against significant harm or exploitation". If this is the case, the review panel may require the assistance or advice of additional agencies, such as adult social care, and/or specialists such as a Learning Disability Psychiatrist, an independent advocate or someone with a good understanding of the Mental Capacity Act 2005.
- g. What is known about the literacy levels of the victim and perpetrator and consider the relevance of this to the Review.
- h. The Panel will consider issues around adults of different generations living together for extended periods and the challenges these may raise
- i. How will agencies/professionals working in other local authority areas with an interest in the homicide be involved, including members of local domestic abuse services and what should their roles and responsibilities be?

6. SUMMARY CHRONOLOGY

The incident took place at a private residence. The premise is occupied by Coralin (Mother) and Kye (Brother of Keith and son of Coralin), and recently Keith and Eme (Keith's girlfriend) had moved in, following their staying in a tent in Aylesbury. They were staying in a double bedroom in the house.

On the morning of the incident, Keith and Eme got up and went downstairs into the living room. Kye's current girlfriend Chantal and his small child were staying overnight with Kye, and they were all still in bed upstairs in their bedroom. Keith and Eme were arguing loudly. Kye went downstairs and told them to be quiet and then returned upstairs. Kye then goes down a 2nd time.

Kye alleges he went into the kitchen to make himself cheese on toast and that Keith then appeared and they had an argument resulting in Kye stabbing him several times. Kye states that he had the knife in his hand and that the assault was not intended. Police evidence suggested the incident took place in the living room. Keith was stabbed with a knife and received stab wounds to the stomach and upper arm area.

Kye called 999 saying there had been stabbing and spoke of bleeding. SCAS alerted the police to the incident and requested attendance.

On the arrival of Police, Keith is in the living room on the sofa clutching the injury to his stomach. He also has a wound to his left shoulder. A police officer in attendance applies pressure to both wounds. Eme (Keith's girlfriend) and Kye were also in the room. Coralin was not at the premises.

Kye tells the officer he is responsible for the injuries and picks up a kitchen knife from under a table. He is told to drop the knife and it is then kicked away. He said he was sorry and that it was an accident.

Kye is arrested for GBH. Keith is conscious at this stage and is talking about it going dark and that he was going to die.

Keith lost a lot of blood and despite efforts by the medical team at Stoke Mandeville Hospital, Keith remained unstable resulting in Disseminated Intravascular Coagulation (DIC) which is a rare life-threatening bleeding disorder, which can lead to organ failure, shock, and death.

The Post Mortem was carried out in January 2017. The Coroner's enquiry was opened and adjourned and following the trial, will not be re-opened.

Although Kye was initially arrested for GBH, following the death of Keith, he was charged with murder. The 6-day trial took place in June 2017. Kye pleaded not guilty, claiming it was an accident. The jury found Kye not guilty resulting in him being acquitted of murder and of an alternate charge of manslaughter at Reading Crown Court.

Keith had a somewhat chaotic lifestyle which may be related to substance misuse, particularly alcohol. His father passed away in 2014. Keith was living with him at the time of his death. He then moved into the YMCA but then he became technically homeless having been evicted from the YMCA in Wycombe in July 2016. He then moved back to his mother's home (Coralin) and had been staying with her and one of his brothers, Kye, in the lead up to the incident.

Keith had been in a relationship with Eme for the past couple of years. Eme has two children, neither of whom live with her. One is living with a family member and one is in care. The relationship between Keith and Eme was a turbulent one, with arguments and disagreements, often being reported to police. Alcohol and drugs were often a factor in what happened. Keith is known to have ADHD¹ and dyspraxia².

He moved into the YMCA with Eme in 2015. Their stay at the hostel was fraught with arguments, shouting, swearing and damage being caused. This led to him having his licence of tenancy revoked in June 2016. This left Keith and Eme homeless, so they started to live in a tent in

¹ ADHD - Attention deficit hyperactivity disorder (ADHD) is a group of behavioural symptoms that include inattentiveness, hyperactivity and impulsiveness.

² Dyspraxia - is a condition affecting physical co-ordination that causes a child to perform less well than expected in daily activities for his or her age, and appear to move clumsily.

Aylesbury. Following a spell in hospital with pancreatitis³, he moved back into the family home, but was later reported as back living in a tent. He again moved back into the family home just prior to his death. He did not work.

Kye was a younger brother of Keith. Kye had a twin, Kane, who does not live at the home property. The twins and Keith had different fathers. Kye did not work and had finished education. He had a girlfriend, Chantal and a child with a previous girlfriend, Gemma. Both occasionally stayed at the home property with Kye. Kye had a volatile and often violent relationship with Gemma.

Both Keith and Kye were known to Thames Valley Police (TVP) prior to the trigger incident, although neither had convictions but had both received police cautions. Both were regularly involved in domestic incident as both victims and suspects, for Keith this was generally with Eme but there were also incidents with his mother and for Kye it was with Gemma.

There had been no reported incidents between the two brothers.

Chronology

January 2016

YMCA –Support Meeting with Keith to discuss complaints about noise and other anti-social behaviour (ASB) issues, including setting off an alarm in December 2015. Keith was issued with Final Warning letter prior to Notice to Quit.

January to April 2016

GP - Several GP notes for Keith relating to smoking, and dermatology matters, including not turning up to a dermatology appointment.

April 2016

TVP - Domestic Incident- Threats to damage/destroy property. During an argument with his mother, Keith allegedly turned gas rings on in the kitchen and threatened to blow the house up. Keith was the initial caller to police, he was arrested but no further action was taken.

May 2016

TVP - Domestic Incident (non-crime). A third party reported that during an argument Keith was having a 'proper go' at Eme and she was crying. This occurred in High Wycombe. Parties taken to YMCA

YMCA – Housing Support Meeting with Keith to discuss regular arguments with staff and residents. Issued with a Final notice, terminating the licence to occupy a room at the YMCA

June 2016

YMCA – Keith wrote to YMCA saying he would walk away from Eme if they were not happy with him. He reports having been to the doctor and planned to see Healthy Minds and Oasis (Drug Treatment Agency), to help him off alcohol and drugs.

GP – Keith visited and updated GP on living at YMCA, not working; feeling low; stressed; poor sleeping; consuming alcohol and using cannabis. Referred to Healthy Minds

³ Pancreatitis - Acute pancreatitis is a serious condition where the pancreas becomes inflamed over a short period of time. The pancreas is a small organ located behind the stomach and below the ribcage.

YMCA – Keith was given a letter from YMCA in which it referred to previous formal notice terminating licence. It refers to him continuing to cause Anti-Social Behaviour (ASB) following his request for his termination to be reconsidered. He was told he had to quit the YMCA by a date in June.

YMCA – Email exchange with Wycombe District Council (WDC) in which YMCA confirmed that Keith was leaving YMCA in June and that he was being evicted because of shouting, swearing and damage being caused (two fridges and a cooker). WDC Housing confirmed he would not be vulnerable under housing legislation and so would not be considered for temporary accommodation by WDC.

AHAG – Keith visited Hub and was assessed.

TVP - Domestic Incident (Common Assault). Third party reports incident. When dealing with the incident Gemma reported that Kye had been physically and verbally abusive to her.

TVP - Domestic Incident (non-crime). Home address - Aylesbury. A third party reported that Eme was distressed and holding her stomach stating that she had been beaten up and thrown out of her home. Two callers reported this. A second call to Police was made by Eme on the following day to request assistance with retrieving property from the home address. This was then followed by a call from Keith who claimed she had barged into the house.

YMCA – Keith evicted.

July 2016

AHAG – Keith attended AHAG offices and was assisted to complete a Job Seekers Allowance (JSA) claim

TVP - Domestic Incident- (Assault with Injury). A third party reported that Keith and Eme were arguing, and they were concerned he was going to hit her, but officers identified him as the aggrieved on de-brief. Eme was arrested but no further action was taken.

Victim Support – Receive referral for Keith as victim of domestic abuse

SCAS – Keith called 999 as he had fallen down some steps and injured his ankle. SCAS attended and confirmed it was sprained. He did not require attendance and the Emergency Department (ED). He reported to SCAS that he was homeless. He has been living in a tent which is currently in his mother's back garden. He was discharged to his mother's address.

GP – Following call by mother of Keith, GP arranged for appointment for Keith to discuss his pancreatitis. The appointment took place. Keith reported he had housing problems and was living in a tent in his mother's garden. Keith had an obvious injury to his eye at the appointment which he claimed was because he was 'messed up' a few days before.

GP – two days after visit to GP, Keith self-referred to A&E concerned he had pancreatitis. A&E discharged Keith into the care of the GP after diagnosing gastritis⁴.

GP – further two days Keith tried to have a telephone consultation to get a medical certificate. He then attended an appointment. He was sign-posted to a local alcohol dependence support group; given a medical certificate and medicated to prevent vomiting.

⁴ Gastritis describes a group of conditions with one thing in common: inflammation of the lining of the stomach.

TVP - Domestic Incident (non-crime). Gemma reported that Kye was being verbally abusive to her over the phone and had previously assaulted her. No resources were available to attend this incident at the time of reporting and Gemma agreed to be seen in the morning. Officers tried to contact Gemma, but it took four days before she responded and then said she couldn't speak then and for the Police to try again later. Nine days after incident the Police spoke to Gemma again and she did not want to engage with the Police anymore.

GP – Keith seen by GP requesting antidepressants. A review appointment was made to discuss his gastritis.

August 2016

Victim Support (VS) – Call made to Keith who requested a text message was sent with VS and NCDV⁵ details and that he would contact them if he thought necessary. He did not re-connect with VS.

GP - Keith seen by GP; sick certificate issued for depression; anti-depressants prescribed; advised to self-refer to Healthy Minds; follow-up appointment made for 1 month and advised to “sort out” his housing issues as living in a tent was not a long-term option; and to consider finding a job.

Healthy Minds – Keith self-referred to the service, but after several attempts to contact him without success his case was closed. His mother was spoken to, but Keith was not living at home and so was not contactable. He was transferred to new referrals where further attempts were made to contact him, but he did not contact the service again.

GP – Healthy Minds advised GP that Keith did not attend his appointment.

AHAG - Reports that Keith was at a grassed location in Aylesbury, in a tent

Connection Support - Visited for first wake-up attempt but Keith was not at location

GP – Keith did not attend for an appointment

Connection Support – Keith and Eme came to AHAG offices. Eme had had a panic attack and came to the offices to use a phone. Keith was spoken to on his own and he said he was OK.

GP – Letter sent to Keith requesting he make a review appointment with GP.

GP – Keith seen in surgery and issued with medical certificate and follow-up appointment made.

TVP - Domestic Incident (Non-Crime, Flagged for Adult Protection). A third party reported that Keith and Eme were arguing, and he was pulling her bag. This was reported by both parties as an incident caused by stress of being homeless.

AHAG – Referral made for Keith into Connection Support and a referral made to Stonham for housing/accommodation.

Connection Support – Worker met with Keith at AHAG premises to complete Stonham application

TVP – Partner of Coralin reported that Gemma had attended his home address looking for Kye and was causing a disturbance. It is suggested that this was because of a new relationship that Kye had and how that would impact on his relationship with his son.

TVP - Domestic Incident (Common Assault & Battery). A third party reported that Keith had punched Eme during an argument. Keith was arrested but no further action was taken. Eme was also

⁵ The National Centre for Domestic Violence (NCDV) provides a free, fast emergency injunction service to survivors of domestic violence

arrested following this report as whilst Keith was arrested she became abusive, she was issued with a caution.

SMART – Keith and Eme met with SMART for an assessment. He seemed to be making good progress and was happy with how things were moving. He talked of getting a place through Stonham. His drinking has gone up considerably since last year. He reports drinking four cans of cider a day or a two-litre bottle. Eme was advised to attend the service's 'drop in' before being assessed.

TVP - Assault with Injury (Wounding W/I to cause GBH). Third parties reported that Kye had stabbed a male during an altercation, it was established the male was attacking a female and Kye intervened in her defence. He was arrested but no further action was taken.

TVP - Domestic Incident- Domestic Incident (Non-crime). During an argument over electricity usage, Keith turned the power to the house off before leaving the property. Keith was the initial caller to the police. Coraline was identified as the aggrieved by officers on de-brief.

September 2016

SMART – Closing Letter sent to Keith as he had not responded to any emails about coming to 'drop in' and to consider progress.

Connection Support – Service reports that Keith and partner have been described as aggressive and abusive by other services and staff have been advised by Line Manager not to see them alone and only at AHAG or public place. Keith's partner is prohibited from being part of the Stonham application for Keith. Worker advised to find out if Keith has any health issues that would be relevant to his housing application.

AHAG – Keith reports he was in a tent with Eme. Discussed a job application and said he was still engaging with SMART.

Connection Support – Worker met with Keith at AHAG. He reports having a job interview. Keith had previously given mother's phone number for contact, but worker reports she had been unable to get an answer. Keith said his mother had new job and couldn't answer the phone. He reported having a GP appointment at which he would ask the GP for evidence of his depression, anxiety, dyslexia and dyspraxia.

GP – Keith attended GP appointment. He reports he is non-compliant with anti-depressants and drinking heavily. Problems with feeling low, sleeping and had thought of self-harm but not followed through. Spoke of trying to find work but due to depression and living circumstances he felt he couldn't. Keith was requesting documentation of a childhood diagnosis of dyslexia. Keith was advised to contact Action Dyslexia for advice on a possible childhood diagnosis. He stated he was in contact with an alcohol dependence team. A formal depression assessment questionnaire was done that gave a score of 24/27 (severe depression)

Connection Support – Keith did not attend AHAG to complete assessment

SMART – Keith attended 'Drop In'. He claims to have reduced drinking but was no further forward with accommodation and he is having very little support from AHAG. He is currently staying in a tent in Aylesbury. Drink diary issued and plans to refer to STARS (Structured Treatment and Recovery Service) considered. He did look healthy and appeared in good spirits and came with his partner.

Connection Support – Worker saw Keith and partner in Town and was ignored by both. Worker to see if they turn up at AHAG next week.

GP – Seen in surgery and reports reduced alcohol intake with the help of alcohol dependence service and so not so depressed. Did not feel he could work because of living circumstances. Depression scoring had improved. Claimed he had also hurt his ankle 6 weeks ago but that it was improving but he was still unable to skateboard.

October 2016

Connection Support – Keith and Partner did not turn up for appointment. No contact made – case to be closed if no further contact made.

TVP - Assault with Injury. During an altercation with a third-party Kye hit a police officer. He was arrested and cautioned for the offence.

Connection Support – Confirmed plan to close case due to no contact.

GP – Letter from A&E stating that Keith was seen with abdominal pain and was admitted.

Connection Support – Keith has been turned down for Stonham housing because of his alcohol dependency. Stonham state that if he worked with Connection Support and SMART for 2-3 months they will assess him. Worker went to ‘grassed area’ and verified he was living with family.

SCAS – Mother calls ambulance for Keith because of stomach pain and vomiting. SCAS take to Stoke Mandeville Hospital for further assessment.

GP – Discharge letter received from Stoke Mandeville Hospital. Diagnosed with acute pancreatitis secondary to alcohol consumption. Hospital advised he engage with community alcohol detoxification unit.

AHAG – Keith reports living with his mother following discharge from hospital. He reports it is overcrowded at his mother’s home. Still taking anti-depressants and is applying for Employment and Support Allowance (ESA)

GP – Telephone follow up made by GP to Keith. He sounded positive and feeling better after hospital admission. Face to face appointment made. Medial certificate issued.

GP - Letter from Benefit Agency saying that no further medical certificates were required for Keith.

AHAG – Spoke with Keith about housing application to AVDC. He claims he took letter re pancreatitis but AVDC say it was not received. Further Stonham application made but he needs evidence of having been engaging with SMART for 3 months. SMART had been chased but not provided the information and support.

November 2016

TVP - Public Order Act Offence. Home address - Aylesbury. A third party reported a disturbance at the address between the occupants of the address and Gemma. Both Gemma and Tom sustained injuries and were treated as suspects in the incident. No further action was taken against either party.

SMART – Keith’s appointment with Worker was cancelled due to worker’s sickness. Keith asked if worker could ring to re-arrange. He mentioned he had GP appointment that day.

AHAG - Made referral into Connection Support as Keith said he was sleeping a tent with Eme. Referral states he had been sleeping at site for a week and drinking alcohol.

GP - Keith stated that he was feeling more positive, since leaving hospital with pancreatitis. He had been living with his mother but would be moving back to the tent the next day. Keith stated that housing outreach were planned to be visiting the following week, to help with accommodation. Keith mentioned that he was seeing the alcohol rehabilitation service on a weekly basis and was not drinking alcohol. Keith was also compliant with his antidepressants. Advised to continue with anti-depressants and that he could contact local psychological service for additional support. Follow-up appointment made for 4 months but to call earlier if needed.

AHAG – Joint re-referral with partner made to Connection Support. Location verified at ‘grassed area’.

Connection Support – Met with Keith and partner at AHAG ‘drop-in’. Discussed Stonham refusal for accommodation. Confirmed that 3 months engagement with SMART was needed.

SMART – Phone call to Keith to re-arrange appointment.

Connection Support – Verified rough sleeping at ‘grassed area’ and advised Keith to contact SMART worker

SMART – Email from Connections saying that Keith needs engagement with Service to enable Stonham referral to be made.

Connection Support – Worker with Keith at AHAG and discussed the need for the SMART involvement. Further appointment made for next week.

SMART – Spoke with Connections worker who suggested once Keith had been engaging with the service for 3 months to call and send letter/email to confirm he was engaging.

SMART – Call to Keith but phone switched off. Text sent to ask him to call back.

SMART – Keith attended his appointment but was 15 minutes late, so the worker was unable to see him as now with another client. He was asked about his welfare and he said he was doing well and is engaging

Connection Support – Keith not given priority by AVDC Housing and turned down by Stonham. Worker to confirm that Keith has been engaging with their service for 3 months and is awaiting the same confirmation from SMART. Old Tea Warehouse (hostel accommodation) in Wycombe was suggested as a referral but Keith did not want to move out of Aylesbury

Connection Support – SMART confirmed that a letter confirming 3 months of engagement would be sent tomorrow by SMART worker

Connection Support – Worker called Keith to see if he had received letter but no answer so message left.

Connection Support – Met with Keith and he has letter from SMART. Worker to complete Stonham application at AHAG in December.

December 2016

Connection Support - Keith did not attend AHAG to complete assessment despite three attempts to contact him.

Aylesbury Women’s Aid (AWA) – Gemma attended appointment with concerns over child contact arrangements with her son's father – Kye. Worker spoke with Connections Floating Support.

January 2017

SMART – Keith texted to say he was ill. Worker to re-contact him next week to see if feeling better.

Connection Support – Keith engaging well and awaiting assessment at Stonham

Connection Support – worker met Keith at ‘drop-in’

SMART – Keith could not attend appointment due to illness. Worker to phone following week to make another appointment.

Connection Support – Completed Keith’s assessment at ‘drop-in’ and sent to AVDC with supporting letter. Meeting arranged to see Keith, next week at Griffin Place in Aylesbury (Griffin Place is Temporary accommodation in Aylesbury suitable only for people accepted as homeless by Aylesbury Vale District Council.)

SCAS – A 999 call was received to stabbing incident in Aylesbury. The Police were asked to attend due to the incident being knife related. The response vehicle had two doctors on board and after initial treatment at the scene, Keith was transported to Stoke Mandeville Hospital under emergency conditions.

TVP – Trigger incident

7. CONCLUSIONS AND KEY ISSUES ARISING FROM THE REVIEW

The Review has not identified any significant issues as part of the review process. There are several lessons learned which are covered below on page 15.

The DHR has established that, other than the actual incident, there had been no evidence of disputes or conflict between the brothers being highlighted or reported to any of agencies, either statutory, commissioned or voluntary.

The most significant issue has been identified as the fact that Keith had problems with substance issues, including alcohol and this appears to have led him to having a rather chaotic life and serious health issues. This included several periods when he has been homeless and living in a tent both in an open area in Aylesbury and his mother’s garden. He had a period of residence with his girlfriend at the YMCA in High Wycombe, but this was short lived because of his behaviour, which ultimately led to him being evicted.

At the time of Keith’s death, he and his girlfriend Eme were staying at his mother’s house. Whilst this is a good-sized home, it was often at a high level of occupancy, as his mother also had on occasions her partner; one her younger sons, Kye; his girlfriend; and on occasions his young child. This meant that there we three generations living under the same roof.

This situation is not uncommon as research⁶ has revealed that in 1996, around 5.8 million 15 to 34-year-olds in the UK lived with their parents; this increased to a peak of 6.7 million in 2014 and remained around 6.5 million in 2016. Although the total population aged 15 to 34 in the UK has increased over the time-period, the percentage living with their parents has risen from 36% in 1996 to 39% in 2016

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<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/families/bulletins/familiesandhouseholds/2016>

Young males were more likely than young females to be living with their parents in 2016. Around 44% of males aged 15 to 34 were living with their parents and 31% of males aged 20 to 34 were living with their parents. This compared with 34% of females aged 15 to 34 and only 20% of females aged 20 to 34. Larger numbers of young adults tending to stay at home for longer may be explained by them staying in education and training for longer, delaying leaving the parental home as they formalise relationships and have children at older ages and it has become more expensive to rent or buy a home.

The term for one brother killing another is Fratricide. It has been difficult to research any reports which researched fratricide. There has been plenty of research on fratricide which is now linked to service men killing service men, so using the term brother as meaning “brothers in arms.”

There has been a piece of work undertaken by Standing Together Against Domestic Violence Organisation⁷, which is a UK charity bringing communities together to end domestic abuse. Their research related to several Domestic Homicide Reviews in which they compared the differences between Intimate Partner Homicide (IPH) and Adult Family Homicide (AFH). This research however is limited in its links with this case however, as there was only one example of sibling killing and in that case the perpetrator was the sibling that had mental health issues and other identified problems, whereas in this case, Kye had no known or identified mental health issues, nor has our Review established significant issues with alcohol or substance misuse problems.

This report does however identify several risk factors, which can be cross referenced with our Review.

- **Family – complex and intergenerational** - this was certainly the case in respect to this family, with three generations being together at times
- **Caring for someone/being cared for by somebody linked to mental health, suicidality, depression** – Keith’s mother had allowed Keith to come back into the family home even though he still had some major issues in respect to depression, and substance misuse and that he had significant health issues caused by his drinking (pancreatitis)
- **Suicide and homicidal thoughts** – there has been no suggestion that Keith had suicidal or homicidal thoughts. Keith however, had depression and was being medically treated for this. He did have some of his clothing removed when in police custody as he had threatened to harm himself. He did not normally present with concerns in respect to self-harm or suicide and so may possibly be attributed to excessive alcohol consumption.
- **History of perpetrator – previous violence against women, pattern of previous criminality, antisocial behaviour** – This was the case for both victim and the accused. Both have had tempestuous relationships, often with violence from both parties in the relationships. Although neither had criminal records, they were both known to the police following domestic incidents. There is also evidence of the brothers being exposed to violence to their mother by previous partners.
- **Sense of entitlement, including to financial resources** – this is not an area that has been identified during the review process, although Keith did not have any access to finance and had no income. Keith showed no obvious actions which might have reflected that he felt any sense of entitlement.
- **Addiction issues** – in this case Kye has not been identified as having any addiction issues, however, Keith has long standing addiction issues, mainly connected to alcohol.
- **Social isolation of victim** – Keith was isolated on occasions from his family due to his behaviour which led to him being homeless. At the time of the incident, however, he was back living with his family

⁷ <http://www.standingtogether.org.uk>

The Panel considers that it is unlikely that this untimely death of Keith could have been predicted by any agency which had a link to either Keith or Kye. Whilst both brothers had problems between themselves and their girlfriends and on occasions with their mother, there was no indication that there had been any incidents which had merited being brought to the attention of any services.

There were specific identified risks for Keith in respect to mental health; depression; alcohol abuse; dyspraxia and ADHD; serious health issues which were either caused or exacerbated using alcohol; violence with his partner; and no identifiable income, leaving him homeless for periods of time. Despite these risks, with no evidence of dispute between the brothers, Services in the main, dealt correctly with Keith when he came to their attention, giving him the support, he needed to access services (although he often refused or failed to turn up at appointments made). There is also evidence of appropriate support given to Keith to fill in forms and suitable explanations were given.

8. LESSONS TO BE LEARNT

Each of the agencies involved in this review considered lessons to be learnt. This analysis is included under each of the agency analysis sections above.

There were several areas where lesson have been learned and, in some cases, where action has already been undertaken to address and others where this has resulted in recommendations, which are summarised below.

Risk Assessments; Risk Management; and Safeguarding

Several services recognised that there was an area of learning regarding risk assessments and managing risk identified through this process. Services which undertake risk assessments need to ensure that the risk assessment process is fit for purpose and is sufficiently challenging to enable key information to be established which will better inform the relevant services about the risks identified and then lead to a better risk management.

There was an example identified in the SCAS report where, despite information indicating that there were significant risk and vulnerabilities, a safeguarding concern was not identified, and so information was not shared. This is being addressed by the Service with all staff being reminded of their safeguarding responsibilities.

Policies

Whilst most of the agencies have policies in respect to domestic abuse and safeguarding, it was recognised that there were examples where these were perhaps a bit too general and that consideration should be given to making them more specific. These have been addressed through recommendations.

It is important that agencies review policies on a regular basis to ensure they meet current guidance and legislation.

Thames Valley Police is currently creating a new policy for contact management which will improve the service offered when contact is made with the service.

Professional Curiosity

This review established that there were several agencies and incidents where the lack of professional curiosity was identified. This led to a failure in identifying that Keith was vulnerable on occasions. There are several incidences through this report where despite services being aware that Keith was living in a tent, had serious health issues and addiction issues, there was very little

investigation into this. Had these been pursued it could have led to a more supportive approach to Keith, ensuring he was offered appropriate and timely support.

There were other examples where police call management staff failed to act on information provided to them by callers, one where information was given that was not directly linked to the call and so was lost and another where just a note was made. This led to a lack of intelligence gathering which may have helped further safeguard a victim. The new Contact Management Policy focuses on Professional Curiosity and so should be addressed in future.

Services need to challenge and be challenging and not make assumptions about a person's circumstances. Staff should be reminded regularly of the need to be professionally curious.

A discussion has taken place with between the Chair of the DHR Panel and the managers of the Adult and Children's Safeguarding Boards who have agreed to undertake several 'Challenge Events'. The challenge events will involve front line practitioners and they will include presentations and case discussions. These would focus on the issue of what professional curiosity is and the importance it plays in safeguarding. The aim of the sessions will be to remind key frontline staff of their responsibilities in respect to professional curiosity and to produce a practice guide for staff.

Case-notes, Improved Recording and Recording Systems

A few incidences are identified in this report where there are examples of case-notes not being as full as they should be. This prevents a full picture of a client being created and can lead to missed opportunities and identification of risk and safeguarding matter.

Services are heavily reliant on staff completing forms which create a record of involvement and create a picture of a person, which helps to identify any vulnerabilities or risks this person may face, leading to a better service and improved outcomes for the client.

Workers are often under excessive pressure due to increasing workloads, but this very important area of work needs to be undertaken in a timely and efficient way to ensure that opportunities to support clients; and identify risks are not missed. Services which have staff who deal with clients must ensure that all relevant staff are regularly reminded of the importance of accurate and timely record keeping and that this is checked through regular monitoring and appraisal meetings.

Communication and Information Sharing

One service, (AWA), recognised that there needs to be more consideration given to the methods of communication. This service is very mindful of how they communicate with victims to ensure that they do not place a victim at further risk from an abuser.

BHT recognised that by improving communication between their service and a patient's GP, there are likely to be improved outcomes for a patient as a GP will be fully aware of treatment provided and any additional personal circumstances which may be relevant. This will allow a GP to be better informed when they next meet with a patient and can then apply some professional curiosity to ensure the patients gets appropriate support and any relevant referrals.

9. RECOMMENDATIONS

Panel National Recommendation

The Home Office is recommended to review and learn lessons from Police Forces in respect to the service offered by Family Liaison Officers following a major incident when the family of the victim and the perpetrator are the same. This should include consideration being given to the support offered to

both the families of the victim and the perpetrator. This review should cover the period immediately after the incident, including support at the scene, through to the period up to trial.

Panel Recommendation

The representative for Thames Valley Police, on the national working group considering the Pre-Release Risk Assessment computerised process, raises the issue identified about the limiting questions currently contained within the computerised process; and offers suggestions to improve the process. (See Recommendation 1 (TVP))

Recommendation 1 (TVP)

The Pre-Release Risk Assessment (PRRA) section concerning issues raised in custody to be altered from being a statement to being clear questions which are required to be addressed.

Recommendation 2 (TVP)

NICHE MINERVA working Group to be asked to consider the following:

- *Removing the generic 'YES/NO' option as to whether any areas of concern were identified for the PRRA so that each point has to be considered individually when the PRRA is being completed.*
- *Adding a 'tick box' for when a DASH form was refused to enable these cases to be easily identifiable.*

Recommendation 3 (TVP)

In early 2018 a quality assurance audit should be conducted to ensure the improvement in risk assessment, safeguarding and data recording expected as a result of the implementation of the SaVE training, improved risk assessment utilising THOR in conjunction with the Contact Management Model and changes to DASH form and IRB DASH check processes has been achieved.

Recommendation 4 (TVP)

When DASH is refused, and the grading is standard for the third time the victim should be re-visited by a police officer to try to encourage them to engage with the process and complete a full and accurate risk assessment.

Recommendation 5 (TVP)

When it is known that a child is in care (Looked After Child- LAC) this should be made immediately clear to any personnel that are accessing that child's record on NICHE that this is the case. This can be completed using the existing Child Protection Flag and the remarks section can be used to highlight the status.

Recommendation 6 (TVP)

Written Guidance on the closure of domestic incidents where victims refused to engage that is utilised by Contact Management should be incorporated in to the domestic abuse operational guidance.

Recommendation 7 (TVP)

When a child protection plan is in place a sig flag⁸ should be utilised on Command & Control and placed on all addresses at which the child stays or visits regularly (both parents' addresses if they live separately and other caregivers) to immediately notify that this may be a concern irrespective of what the incident is and who is involved.

Recommendation 8 (AVCCG)

General Practitioners to be reminded to flag an adult at risk within the GP computer records as recommended as good practice by Care Quality Commission (CQC)

Recommendation 9 (AVCCG)

To encourage within General Practice professional curiosity when enquiring about possible Domestic Violence, and to ask questions specifically around unusual or suspicious injuries. To be aware of the risks of gender bias, when assessing patients with unexplained injuries.

Recommendation 10 (AVCCG)

To increase awareness of the Adult Safeguarding Threshold Document to all staff working in General Practice, that was launched this year by Buckinghamshire Adult Safeguarding Board.

Recommendation 11 (SMART)

Continued focus on risk management within SMART Buckinghamshire, follow up peer audit and management audit to take place within the next 3 months.

Recommendation 12 (SMART)

Continued focus on case notes; audits to be carried out in the next 3 months based on the SMART practice standard.

Recommendation 13 (SMART)

This recommendation has been removed as it related to a newly commissioned service and was not relevant to SMART

Recommendation 14 (SCAS)

SCAS to internally share the learning from this incident, particularly in respect to the missed opportunity of completing a safeguarding referral when presenting circumstances indicate that a person is vulnerable or at risk.

Recommendation 15 (AWA)

The Outreach Centre Manager to consider developing a check list of activities that should be carried out or followed up for each referral. It needs to be borne in mind that each client is an individual and as such the nature of the work varies from client to client.

Recommendation 16 (AWA)

The Outreach Centre Manager to carryout spot checks on random case files on a regular basis. This will enable consistency and conformity of the service provided by the IDVA team.

Recommendation 17 (AWA)

⁸ A sig flag is marker on Command & Control that is applied to specific locations for the purpose of protecting people- it highlights what the issues at an address may be and identifies people at risk who may be at the address

The Leadership Team, with input from all workers, to explore innovative ways of engaging with clients who are challenging to engage with.

10. GLOSSARY OF TERMS

A&E	Accident and Emergency
ADHD	Attention Deficit Hyperactivity Disorder
AHAG	Aylesbury Homeless Action Group
AVCCG	Aylesbury Vale Clinical Commissioning Group
AWA	Aylesbury Women's Aid
BCC	Buckinghamshire County Council
BHT	Buckinghamshire Healthcare Trust
CPP	Child Protection Plan
CSC	Children's Social Care
DASH	Domestic Abuse, Stalking and Harassment (plus honour-based violence)
DHR	Domestic Homicide Review
ED	Emergency Department
ESA	Employment Support Agency
GBH	Grievous Bodily Harm
GP	General Practitioner
IDVA	Independent Domestic Violence Advisor
IMR	Individual Management Review
IRB	Information Research Bureau
JSA	Job Seekers Allowance
LAC	Looked After Child
NCDV	National Centre for Domestic Violence
NHS	National Health Service
NICHE	Police record management system
PRRA	Pre- Release Risk Assessment
SCAS	South Central Ambulance Service NHS Trust
STARS	Structured Treatment and Recovery Service
THOR	Threats, harm, opportunity and risk
TVP	Thames Valley Police
VS	Victim Support
WDC	Wycombe District Council
YMCA	Young Men's Christian Association