Northampton Community Safety Partnership

Executive Summary

Of

Domestic Homicide Review
DHR 004

Report into the death of a man aged 55 years, in June 2016

Report produced by Malcolm Ross M.Sc.
Independent Chair and Author

June 2018

List of Abbreviations

CAT	**Clinical Assessment Team**
CCG	Clinical Commissioning Group
CRH TT	Crisis resolution Home Treatment Team
DASH	Domestic Abuse, Stalking and Harassment Risk Assessment form
DHR	Domestic Homicide Review
EMAS	East Midlands Ambulance Service
GP	General Practitioner
IMR	Individual Management Review
LGBT	Lesbian, Gay, Bisexual Transgender Forum
NCMHT	Northampton Community Mental Health Trust
NCSP	Northampton Community Safety Partnership
NDAS	Northampton Drugs and Alcohol Service
NHFT	Northamptonshire Health Foundation Trust
NGH	Northampton General Hospital
NPH	Northampton Partnership Homes
RTC	Road Traffic Collision
SA 1	Safety Alert form (Police)
SIO	Senior Investigating Officer
SOVA	Safeguarding Vulnerable Adults
TBI	Traumatic Brain Injury
VARM	Vulnerable Adult Risk Management

An Executive Summary Into the death of a man aged 55 years in June 2016

Introduction

The relationship between the Victim, aged 55 years at the time of his death, and the Perpetrator, aged 30 years, is complex and aggravated by the use of alcohol by both men.

The men met whilst receiving treatment at a head injuries clinic, both having sustained injuries in separate incidents some years before they met.

The Perpetrator was the father of a child. He was separated from the child's mother. There is a significant history of violence between the two men and also a degree of sexual contact between them both. Both men are described as men who have sex with men. There is evidence of sexual contact between the men whilst at the head injuries clinic.

The Perpetrator was known to have taken advantage of the Victim financially. However, due to their lifestyles both men should have been seen as being vulnerable. There were numerous calls to the police and ambulance services for assistance and reports of assaults on each other. There were also multiple admissions and attendances at the Emergency department of a local hospital for both men. Whilst it was known to police and ambulance personnel that the men were associating and living together, none of these incidents were considered to be domestic abuse but rather disputes between two drinkers.

The perpetrator was known to associate with street drinkers, one, a woman, was alleged to have been his girlfriend at some stage. She was also known to the Victim. She was overheard to make threats to kill a 'paedophile' referring to the Victim. She later bragged that she had killed someone.

In June 2016, Police went to the Victim's flat. They forced entry and discovered the dead body of the Victim. He had suffered serious injuries. A murder investigation was commenced. The Perpetrator was arrested along with the woman mentioned above and two other men who were present at the time. All four arrested were charged with the Victim's murder but this report relates only to the Perpetrator and the Victim as there is no evidence of a relationship conducive to the definition of Domestic Homicide between the Victim and the other three defendants.

In July 2017 at Northampton Crown Court, the Perpetrator was convicted of the murder of the Victim and sentenced to Life Imprisonment to serve a minimum of 23 years. A 59 year old man and a 36 year old woman were also convicted of the Victim's murder and received an identical sentence.

A 51 year old man was convicted of manslaughter and received a seven-and-a-half year sentence.

The Purpose of this review and its Terms of Reference and procedure of this review are contained in an Appendix to this report.

The following matrix identifies the family members in this case, as represented by the following key:

Name	Referred to in this report as
Victim 'V'	The deceased
Perpetrator 'P'	Person charged with the murder of the Victim
Exp	Ex-Partner of the Perpetrator and mother of P's child

A summary of the sequence of events

The Overview Report for this review extends to over 50 pages and the chronology over 400 pages. They both give a detailed history of the relationship between the perpetrator and the Victim. The Overview Report also comments of the fact that the Perpetrator was written to offering him the opportunity to participate in this process and to give his consent for his medical records to be disclosed by Health colleagues. Neither he, nor his legal representative has responded to the letters resulting in the Health colleagues being unable to disclose details of the Perpetrator's health records. This is due to uncertainty of the interpretation of the Home Office Guidance of December 2016 regarding the disclosure and use of medical information without the consent of the Perpetrator. The report therefore lacks any evidence that the Perpetrator's head injury and any subsequent treatment affected the way he behaved towards the Perpetrator and others in his life. Reference can be made to the fact he allegedly had sustained such an injury because he referred to that fact to police and other agency members.

This report will comment of the lives of Victim and then the Perpetrator before their lives merged and will then summarise life when evidence shows they were together.

The Victim was known to have a problem with alcohol as far back as 2004, which may have resulted in some mental illness. It is also known that by 2007 he was using illicit drugs. In January 2013, he was found in his house intoxicated and living in dirty conditions. A referral was made to his GP. His mother called an ambulance after finding the Victim in a drunken state. He reported he had consumed 4 bottles of whiskey and 24 cans of lager over the last few days after a period of 11 years without alcohol. Ambulance personnel noted the unclean and unsafe condition of the Victim's flat and considered that there was a degree of self-neglect. He was admitted to hospital but discharged within a few days.

Social Care made arrangements for a cleaning agency to make a one off visit to the flat to clean it and ensure conditions were safe for the Victim to live there.

The Victim contracted cellulitis in his legs. The East Midlands Ambulance Service made repeated attendances to the Victim's flat responding to calls from him or his mother for assistance. In May they found him intoxicated. The floor of the flat was covered in urine, vomit and empty alcohol bottles. The Victim's mother was concerned that the Victim was binge drinking with another man, suspected to be the Perpetrator. He was taken to hospital but discharged himself the following day. Self-discharging from hospital was something that he and the Perpetrator did so often during the course of the time period

of this review. The Victim frequently requested repeat prescriptions of methadone and other medication from his GP, saying that he had lost them or his medication had been stolen. He even reported that he had dropped the bottle of methadone and it had smashed. He was given another prescription. It was suggested by S2S (a support organisation) that a daily collection of his medication would be better thus reducing the risk of being stolen.

Around November 2013, the Victim's mother died and that affected him significantly. His drinking escalated considerably and there is no doubt he became even more vulnerable during this period of time.

Paramedics attended to the flat where the Victim had fallen, was having a seizure or felt unwell. One Paramedic made a referral to the Victim's GP. Staff at the head injury clinic noticed that the Victim had become more reclusive. He began to report property stolen but there was no consistency in his reports and the property reported stolen was often found within his flat. He was allowing his flat to be used by drug users which caused problems with the neighbours who called the police on several occasions. Officers that attended submitted a Safeguarding Adult Referral Form (SA1).

In December 2013, the Victim had a Mental Capacity Assessment and it was deemed that he had capacity to make decisions about who he associated with and who he invited into his flat. It was decided that a Vulnerable Adults Risk Management (VARM) meeting was unnecessary as he was receiving and accepting the appropriate support packages.

It was during this month that the Victim met the Perpetrator at the head injury clinic Headway, and although they were not cohabiting at this time, the Victim developed a strong attachment to the Perpetrator, following him around and wanting to know where the Perpetrator was at any given time. Staff at Headway considered the relationship as unhealthy. The Care Manager did not take any action other than to speak to the Perpetrator, but it seemed that, despite the fact that both men were alcohol dependent and were more vulnerable when intoxicated, it appeared that the Perpetrator saw the relationship as a safety behaviour linked to his underlying anxiety of being alone.

There followed a series of hospital admissions for the Victim, mainly alcohol related. He knew of the risk of stopping drinking suddenly which would result is possible seizures, but he continued to binge drink causing repeated admission to the Emergency Department via the Ambulance service. Despite being offered help and support from S2S he discharged himself from their services, thinking that as he had given up drinking for a number of weeks he no longer needed their services.

The Victim was referred to the Crisis Resolution and Home Treatment Team (CRHTT) in February 2014 with anxiety symptoms. He had taken 28 Temazepan tablets in a few days. He disclosed a long history of taking illicit substances including speed, weed, injected methadone, injected speed and misusing morphine since he was 16 years of age. He did however deny any current use of these substances. He was referred back to S2S.

In April 2014, concerns were raised at Headway when both men were found in bed together. Such behaviour was considered inappropriate. There had also been incidents where they were sharing needles in the process of taking illegal drugs together.

As far as the Perpetrator is concerned, he was known to the police and had several previous convictions. It is thought that he had a serious traffic accident in 2008, which according to him, resulted in a head injury causing short term memory loss, low mood,

poor sleep, reduced motivation, increased alcohol use, and verbal and physical aggression.
He had a child with a partner ExP but that relationship ended due to his excessive drinking and domestic abuse. He had several appointments for mental health assessments but his attendance was spasmodic. In March 2010 he was subject to a restraining order to prevent him threatening his grandparent and his mother. Concerns had already been raised by the Child Protection Team about the safety of Exp and the child. It appeared that P had a significant dependency on alcohol and he was unable to manage his thoughts, feelings and associated behaviour. There is no evidence of a referral being made regarding the domestic abuse.

On 7th June 2010, as a result of his aggression at previous appointments, the Perpetrator was discharged from the Traumatic Brain Injury (TBI) Team. At about the same time he was cautioned by the police for criminal damage.

Following an incident in January 2010 when, after drinking heavily, the Perpetrator fought with ExP and butted her in her face, he had several appointments with NHFT and NDAS. At most of the appointments he attended smelling of alcohol.

In May 2011, the Perpetrator refused to leave ExP's house after he had turned up intoxicated. Police were called. There was a Child in Need meeting with Children's Social Care and it was decided that ExP needed some supervision. It was later decided that the Perpetrator should not have access to the child at ExP's house as he was continuing to excessively abuse alcohol.

The Perpetrator continued to consume alcohol. He would turn up at his grandparent's house. They could see that he was in a state. His solicitor then contacted P informing him that he had been awarded £15,000 compensation from his road accident. He was told that his appointment with a Consultant Clinical Forensic Psychologist would stop if he accepted the money. He did accept the money which was spent in a matter of months.

For the remainder of 2011 and into 2013 the Perpetrator continued to drink alcohol and decline help and support. There were numerous attendances by ambulance to hospital and an overdose of prescribed medication and alcohol in February 2013.

By March 2013, the Perpetrator's condition had deteriorated. He was drinking 70 units of alcohol per day and a suggestion was made that he be admitted to a privately owned care service to encourage those with brain injuries to reduce their drinking. Cost was an issue with this suggestion and there followed months of debate before a decision was finally made, during which time he continued drinking. He was frequently found in public places intoxicated and suffering from seizures and was taken to hospital where he often discharged himself within hours of his admission.

In May 2013, the Perpetrator's child was made subject of a Child Protection Plan.

In July 2013, an offer to accommodate the Perpetrator in Lanarkshire was received by Social Services at a cost of £4000 for a 3 week package. If alcohol was found to be the main issue another package at £700 per week would be available. No decision was made. Later in July another offer was made for a package in Merseyside and after conversing with Merseyside it was decided that the treatment needed would be available in Northampton after all.

In August 2013, the Perpetrator's assessment for a Residential Rehabilitation Placement was conducted. It appeared positive but there were further queries about the cost so

another quote was requested and an additional delay took place. On 2nd September 2013, the Transitional Rehabilitation Unit sent an email to S2S with details of the cost to provide their services to the Perpetrator. S2S would seek approval.

During September 2013, the Perpetrator told an S2S worker that the Victim, who he described as a sexual predator rather than a head injury victim, had sexually abused him whilst he had been drunk. He also stated that the Victim had pretended to be his uncle when he had been talking to police and ambulance personnel.

An Adult Social Care worker requested the Perpetrator's GP to conduct a mental health assessment. He had been found unconscious at Headway with the Victim with his hands down the Perpetrator's trousers. There was concern about his moving to residential care as his vulnerability could pose a risk to other residents. The matter was left with the GP. It was discovered that there was a 9 month waiting list for an assessment and before the Perpetrator could be considered for residential care he would have to have a formal mental health assessment because he had never had one before. That meant another delay in the decision to find him somewhere to reside with care included.

In October 2013, an offer was made to the Perpetrator for residential care as it appeared that he 'turned the corner' and stopped drinking. However two days later he was found intoxicated. Nothing changed over the next few months.

By the end of 2013, the funding for a placement for the Perpetrator's rehabilitation had still not been settled and during the period of waiting from March 2013, he was often found intoxicated in public places and taken to hospital by ambulance, where he would discharge himself.

There were occasions when the Perpetrator was taken to hospital suffering from an alcohol related seizure and within hours he was back on the streets calling for another ambulance having discharged himself from hospital.

At the end of November 2013 the Perpetrator was allocated a place in residential care. He handed the keys to his flat back to the council. However he failed to stay there on several occasions and was found drunk at the Victim's house. By December the accommodation placement had been withdrawn and he was homeless. Social Services found him a bed and breakfast on a temporary basis, but he was soon expelled from there due to his intoxication. The Victim agreed to withdraw money from his own account to pay for the Perpetrator's alcohol.

During December 2013, the Perpetrator was found in a drunken state and was arrested for criminal damage to a hospital sign whilst intoxicated.

From this point in the sequence of events the Perpetrator and Victim were in a relationship which developed into a sexual relationship. The relationship is described as being 'men who have sex with men' rather than any other description of a relationship between two men. It is known that the Perpetrator had relationships with women as well as the Victim.

In January 2014, the Perpetrator may be allocated accommodation at Oakfield Residential Care to be funded by Northampton Adult Social Care. Confirmation of this was awaited.

During January 2014, the Perpetrator continued to drink and call EMAS for assistance. Often he was taken to hospital but left before he was seen by Emergency Unit staff.

In March 20014, the Victim complained that the Perpetrator had taken his wallet and stolen money. Police were involved but nothing came of the report.

In April 2014, both men went missing, apparently to London, on a binge drinking episode. Gateway staff was very concerned about the Perpetrator's deterioration and his mental and physical health over the previous 2 weeks. Later that month the Perpetrator complained that the Victim had arrived at his flat with a large quantity of alcohol. Within an hour an ambulance was called to the Victim who reported that he had been stabbed in the head and liver. On arrival, EMAS crew found the Victim uninjured but intoxicated.

EMAS crews became unhappy about the condition that the men were living in and reported beer cans, glass bottles, vomit and other rubbish strewn around making, what they considered to be, an unsafe environment for two vulnerable people to live in. Also of concern was the presence of children's toys in the house, perhaps indicating that the Perpetrator was having access to his children.

At the same period of time it was noted that the funding for the Perpetrator's residential accommodation funding had still not been settled.

Throughout the remainder of April and during May 2014, the police and EMAS were constantly called to both the Perpetrator and the Victim, responding to calls concerning alcohol abuse. Many of the calls resulted in false calls or attendances at hospital, them leaving before being treated. On one occasion the Victim attended the Emergency Department four times in 48 hours.

In May, a Professionals Meeting at Headway was held and it was decided to complete several Decision Specific Mental Capacity Assessments with the Victim as soon as possible. Later that day the Victim attended the Emergency Department of NGH with hematemesis and PR bleeding. He discharged himself before being seen.

On 29th May 2014, attempts were made at Headway to undertake the Mental Capacity Assessment on the Victim but it was unable to be completed and more information was required. The Victim did say that he didn't feel safe at home and it's times like these that he phoned the emergency services.

June 2014 was similar to previous months in terms of police and EMAS attendances to both Perpetrator and Victim. During this month Headway and S2S met to discuss the Perpetrator. He had been intoxicated for the majority of the previous 2 weeks and had been taking legal highs. His benefits were to be stopped within the next 3 weeks as he had failed to attend work related appointments. He had problems with his flat that Headway was attempting to resolve, but he only had a mattress as his furniture.

On 25th June 2014 at 01.17 hours, the Perpetrator contacted the Police stating that he and his uncle had been assaulted by a number of men and he had lost the keys to his address. The Perpetrator often called the Victim his uncle, presumably to disguise the relationship the men had with each other. The Police spoke to the Perpetrator who admitted making a false report in order that the Police would gain access to his address. The ambulance service also attended. A little later that day the Victim presented himself at the Emergency Department at the hospital with chest pains. He did not wait to be treated and left.

On 8th July 2014, an email from Aidcare to a Social Worker stated that Aidcare were considering withdrawing the service for the Victim due to non-engagement. It appears that the Victim was involved in a relationship with 2 people that were constantly taking

his money and his willingness to continue to be involved with them is making his ability to progress impossible.

In August 2014, it was determined that the cost of residential accommodation for the Perpetrator was to be in the region of £79,000. The Young Adults Team was prepared to continue to fund the Perpetrator's placement at Headway for three days per week.

It was noted that the conditions at the Perpetrator's flat had deteriorated. He had no gas, electricity, hot water and no food. His benefits had been stopped. It was suggested that he obtained a food parcel. Headway offered support in that he could shower at Headway and do his washing there. Headway staff would clean his flat for him. The S2S representative expressed their concerns about the Perpetrator's welfare.

On 11th August 2014, there was a meeting between S2S and Adult Social Care regarding the funding for the Perpetrator to attend a residential rehabilitation placement in Merseyside. It is clear that this matter had still not been settled and the Principal Social Worker from Younger Adults Team indicated that as the Perpetrator had never been detained in a Psychiatric Hospital under Section 3 of the Mental Health Act, he would not be eligible for a Section 117 After Care Money Payment.

During August 2014, police and EMAS attended on 9 occasions to either the Perpetrator or the Victim for alcohol related symptoms, most of which resulted in no treatment at hospital before they discharged themselves.

In September 2014, Headway considered withdrawing their services to the Victim because of his non-engagement. During this month police and EMAS attended on another 10 occasions.

By October 2014, the Perpetrator had agreed to move into a small residential unit when finances were determined. A Mental Capacity Act Assessment showed he had the capacity to make such decisions. A meeting at Headway a week later discussed the alleged sexual abuse of the Perpetrator by the Victim while the Perpetrator was unconscious due to an alcohol related seizure.

In December 2014, the Perpetrator moved into a residential accommodation but within 2 weeks he was reported missing from that accommodation. He was found by police at the Victim's address in a state of intoxication. The following day he was asked to leave the residential accommodation as the management considered him to be an unsuitable tenant due to his alcohol consumption. He was found bed and breakfast accommodation by Social Services. A doctor from the Head Injuries Unit of NHFT described how the Perpetrator was discharged from residential accommodation and that he was able to consider the pros and cons of leaving and understood that re-admission would probably not be agreed. The Perpetrator had refused to engage with any programmes and had constantly sought the opportunity to drink in the local village.

It is clear during this period of time that the Victim was being exploited by the Perpetrator and other associates. There is evidence that he would withdraw money from his bank account to provide alcohol for others to drink at his flat. He was admitted to hospital with alcohol induced acute pancreatitis and abdominal pain. Records show that he said the Perpetrator was his nephew. The following morning the Victim became agitated and left the ward.

Just before midnight on 26 January 2015, the Perpetrator called the Police saying he thought he had broken the Victim's jaw whilst play fighting. On arrival of the Police, the Perpetrator further assaulted the Victim by punching him in the stomach and hitting him with a can of lager in his face. The Perpetrator was arrested and admitted the offence

but the Victim stated he did not want to make a complaint. Nonetheless, acting positively, the Perpetrator was charged with the offence, only for the charge to be discontinued by the Crown Prosecution Service despite objections from the Police.

On 18th March 2015, the Perpetrator was seen by a Lifestyle Counsellor who reviewed his situation. He declined to be referred regarding his alcohol intake and also declined to give a reason why he didn't want to be referred. He terminated the conversation

The Perpetrator's attendances to hospital continued. On the morning of 9th April 2015, the Perpetrator attended the Emergency Department following an alcohol binge. He was diagnosed with Acute Chronic Pancreatitis and discharged to his GP. Later the same day, the Perpetrator called EMAS suffering with alcohol withdrawal tremors, rectal bleeding and pain. He had taken pain killers with alcohol. He was conveyed to NGH. He again attended the Emergency Department of 18th April 2015, with abdominal pain, he was seen and discharged.

On 29th May 2015, the Victim called EMAS. He had injected heroin and speed into his groin and had visited his GP feeling unwell. He had been told that he needed the Emergency Department at hospital. He walked into town and on experiencing pain with his breathing he went home and dialled 999. He stated he thought he was dying of Cancer. He was taken to NGH where he named the Perpetrator as his nephew. He was later discharged with advice to supply his own pain relief.

A significant event took place on 9th July 2015, when the victim reported to the Police that he had been assaulted at the town's racecourse. He later stated that this was a false report. 2 days later at 04.00 hours the Victim again contacted the Police stating that 2 men had entered his address with carving knives and had assaulted him. During the attack they threatened to kill him. He had sustained injuries and an ambulance was called to take him to NGH. During the following Police investigation, the Victim named the Perpetrator as one of the men, and also named the second person. He refused to make a statement or pursue a prosecution and he stated he was in love with the Perpetrator. The Police considered a victimless prosecution, but due to discrepancies in his account and the lack of forensic or other evidence, no further action was taken other than submitting an SA1 referral form.

On 14th July 2015, Social Care noted that the Victim may be being financially exploited and named the Perpetrator as always around when the Victim has money.

In August 2015, S2S saw the Perpetrator. He was homeless but drinking 35 units of alcohol per day and spending up to £100 per day on illicit drugs. He was classed as a vulnerable adult who was at risk of heroin addiction.

In September 2015, the Victim made an application to move house on the basis of the attack recorded in July. NPH IMR indicates that this should have been followed up in July at the time of the attack and not have waited until September.

In October 2015, the Victim admitted that he had been taking cocaine for three weeks with friends and he had given them money. Both he and the Perpetrator were arrested for entering the home of a vulnerable person. They were bailed but failed to appear at Court. The Victim was later arrested for stealing property from shops that he said he was going to sell later.

Later that month the Perpetrator was evicted from his accommodation due him being intoxicated and offensive and he threatened to kill himself by hanging.

Calls to the ambulance service continued throughout November, mainly for the Perpetrator, but police issued the Victim with a retail exclusion notice due to his constant shoplifting.

In December 2015, the Victim was referred to mental health as he told his GP he felt he was spiralling out of control.

During January to March 2016, the Perpetrator was seen by ambulance staff and hospital staff concerning a variety of reported illnesses but usually these resulted in his not co-operating or failing to attend for appointments.

On 1st April 2016, a neighbour of the Victim called NPH giving information about the Perpetrator abusing and taking advantage of the Victim. The Housing Officer replied that he had been to the flat and had got no concerns. The Housing Officer had made a visit on 15th March 2016 and all had seemed in order.

It was on that day that the ambulance responded on two occasions to the Perpetrator alleging illness. EMAS submitted a safeguarding referral to social services about their concerns regarding the relationship between the Victim and the Perpetrator.

That referral was followed up in 28th April by a Housing Officer and a Police CSO who saw the Victim at home. The Victim denied that the Perpetrator was behaving towards him as described by the neighbour and that all was normal with the relationship. The Perpetrator was asleep at the time on the sofa. The Victim was not seen alone.

In May 2016, the Victim attended at hospital with a lacerated eyebrow. He said that the Perpetrator had assaulted him but he didn't want anything done about it or the police involved. The hospital staff considered the Victim to be scared of the Perpetrator and submitted a referral form to social services.

In June 2016 the Police were called by a member of the public who said a man was trying to get into the Victim's address. Police attending found the Perpetrator outside not causing any problems and he was taken to his grandmother's house. He was intoxicated.

The Perpetrator attended the Emergency Department with a suspected heroin overdose the following day. He was treated in the Emergency Department and was admitted for continuing reversal treatment.

The next day Police attended at the Victim's house and found him dead. He had suffered horrific injuries. The Perpetrator and three other people were arrested.

On Wednesday 12 July 2017, at Northampton Crown Court, the Perpetrator was convicted of the murder of the Victim and sentenced to Life Imprisonment to serve a minimum of 23 years. A 59 year old man and a 36 year old woman were also convicted of the Victim's murder and received an identical sentence.

A 51 year old man was convicted of manslaughter and received a seven-and-a-half year sentence.

Views of the Perpetrator's family and the Victim's neighbour

Following the trial of those convicted, contact was made with the grandparents of the Perpetrator and the neighbour of the Victim, all of whom wished to engage with the review process.

A detailed account of what they told the report author is contained in the overview report, but in summary the grandparents told how the Perpetrator had been violent and had abused alcohol since he was in his 20's. He had lived with them but caused damage to their property as he had to his mother's house. He had a car accident and sustained a head injury but after hospital treatment there was no long lasting effect or further treatment needed. They doubted his claim that he had a head injury and said that he would use that as an excuse when he 'didn't get his own way'.

The grandparents met the Victim and were concerned that the Perpetrator was taking advantage of him on the basis that the Victim genuinely thought the Perpetrator cared for him as he cared for the Perpetrator. The grandparents thought it was clear that the Victim had some sort of learning difficulties.

The neighbour stated that she knew the Victim very well and was concerned when the Perpetrator moved into the Victim' flat. The neighbour said that the abuse by the Perpetrator on the Victim was obvious. That the perpetrator took everything that the Victim had and even threw the Victim out of his own flat. She saw injuries inflicted by the Perpetrator on the Victim, but the Victim would not complain or do anything about the life he had with the Perpetrator.

Analysis and recommendations

The evidence from the Perpetrator's grandparent and the neighbour of the Victim paint a lifestyle of the Victim as being one of constant bullying, violence and exploitation.

The Perpetrator befriended the Victim in circumstances that convinced the Victim that there was an affectionate and even sexual relationship between them. Both the grandparents and the neighbour are of the opinion that the Victim had some sort of disability in that the grandparents described him as being 'a bit slow'. What is clear is that the Victim was unable to make clear and safe decision about his friends and relationships.

There were concerns identified about the Victim's welfare but often not acted upon or there was a delay in taking any action. His vulnerability was not recognised and acted upon. He received services from Drug and Alcohol Outreach, Tenancy Support and Community Support packages weekly, two weekly and monthly.

It was at Headway where the Victim met the Perpetrator, who also, it was alleged, was a head injury victim and was therefore considered a vulnerable person. This is disputed by the Perpetrator's grandparents.

The Victim lived in a flat that was often described by various professionals as being filthy dirty, strewn with empty alcohol bottles, with little bed clothing and on occasions showing evidence of drug misuse therein. Information later obtained from the Victim's neighbour indicates that whilst the Victim would be given blankets, bedding, food and food parcels from the local church, the Perpetrator would take these items for his own use leaving the Victim without. It is also suspected that the Perpetrator was taking the Victim's medication from him which necessitated the Victim requesting repeat prescriptions from his GP. The Victim felt powerless to complain and in any event the Victim felt an emotional bond between himself and the Perpetrator, which prevented him from complaining. He also lived in fear of physical violence from the Perpetrator and no doubt the perpetrator's associates.

EMAS responded to an extraordinary number of calls from the Victim and the Perpetrator, and on occasions made the appropriate referral for help and support for the Victim, and even going to the lengths of contacting the Victim's GP directly with their concerns.

In addition there was a joint effort between NPH, Social Services and Bromford Housing to clean the Victim's House and it is clear that there are occasions when Headway and other agencies did all they could to improve living and health conditions for the Victim. Social Services arranged for a private Care Company to clean and improve the Victim's living conditions, but the company refused to enter the flat due to the presence of razors, needles, syringes and faeces.

A decision was made by Social Services for a Capacity Assessment to be undertaken on the Victim. This concluded that the Victim did have the capacity to invite who he wanted to into his flat and that a VARM meeting was unnecessary. It is not clear however, what the Victim had the capacity to make decisions about, his lifestyle, his continued drinking, his relationships, the care of his finances or who he invited into his flat. The review considers that this is a critical issue when considering the person's safeguarding needs and makes the following recommendation.

Recommendation No 1

Agencies making reference to a person's mental capacity should be precise as to what decisions the person can and cannot be deemed to have capacity to make especially where the person's safeguarding is involved.

There were occasions when appointments for treatment for the Perpetrator were cancelled by someone other than the Perpetrator. For instance, his grandmother calling CMHT saying that the Perpetrator had been drinking to excess and could not make the appointment. There were no checks to confirm that this was a genuine cancellation. The panel make the following recommendation.

Recommendation No 2

Cancellation of appointments by known vulnerable people should not be accepted on face value and should be checked and confirmed, especially when a family member is expressing concerns regarding the behaviour and demeanour of the vulnerable person.

Consistent and effective provisions of services for both the Victim and the Perpetrator was hampered by their inconsistent levels of engagement, apparent unwillingness to take an active role, ongoing repetition of harmful behaviours, repeated misguided expectation of service provision and consistent misuse of services. However, services fell short because of a lack of proactive, joined up multi agency work and different services working to different agendas.

In an attempt to improve service provision in these circumstances the panel make the following recommendation.

Recommendation No. 3

All agencies should be aware of the need to consider calling for a multi-agency meeting with regard to those known vulnerable people who are regularly calling for assistance from a variety of agencies in circumstances when the calls are unnecessary or inappropriate.

The Perpetrator's grandparents described how the Perpetrator had large amounts of money from benefit enhancements and compensation following a car accident and how he squandered it within a short period of time on alcohol and drugs. NPH practitioners became aware of possible drug abuse at the Victim's home and found weapons and drug paraphernalia but there is no record of a referral being made.

Recommendation No 4

Northampton Partnership Homes should be aware of the need to make referrals to the police and /or social services where evidence of criminality is observed by NPH personnel in the course of their duty and should always be mindful that a safeguarding opportunity may be missed if such a referral is not made.

It was decided that the Perpetrator would benefit from residential accommodation at establishments that specialised in the treatment of those with head injuries and had other complex needs including alcohol and substance misuse. There followed months of negotiations with various authorities and establishments as to where the financial contributions for his treatment was coming from. During this time there were numerous occasions when the Perpetrator abused alcohol and opportunities to address his disruptive lifestyle were missed.

Recommendation No 5

Where issues of funding for accommodation arises Adult Social Services should take a leading role in the coordination of efforts to secure funding, which should be completed as soon as possible and not prolong a person's vulnerability in delaying the decision making process.

EMAS were called to either the Perpetrator and/or the Victim over 90 times, sometimes three times in the same day. The majority of the calls resulted in them refusing treatment or being taken to hospital and discharging themselves before being treated. As stated above, on many occasions EMAS personnel made the correct referral and even contacted the relevant GP , which is recognised as 'Good Practice'. EMAS are content that the use of their 'Frequent Callers Team' is sufficient to monitor repeat callers and do not seek a recommendation here.

Conclusions

The Victim and Perpetrator in this case were vulnerable people. However, it was not until the information was obtained from the Perpetrator's grandparents and the Victim's neighbour, that the extent of vulnerability of the Victim was appreciated.

The description of the abuse on the Victim inflicted by the Perpetrator and those convicted with him is horrific. Incidents of gratuitous violence, financial exploitation and extreme bullying were something that the Victim lived with. He would not and could not complain. He was under the misapprehension that the Perpetrator cared for him. The Victim needed someone in his life after the death of his mother and thought that the Perpetrator cared for him, when in reality the Perpetrator only abused him. The act of mutilation of the Victim after his death was the final insult that the Perpetrator could inflict on the Victim.

The Victim was stuck in that relationship which was controlled by the Perpetrator, who was able to have anything that the Victim had and do whatever he wanted to the Victim in the full knowledge that the Victim would not complain.

Incidents when police and other agencies became involved were dealt with in isolation. The Victim was not seen on his own and was reluctant to complain and assist in prosecuting the Perpetrator. The reports of abuse and damage were not recognised as being domestically related even though there were occasions when the Victim indicated his love for the Perpetrator. The Victim's vulnerability was not recognised.

Concerns raised about the Victim's lifestyle, associates and his ability to stay safe from exploitation were not acted upon with any haste and often there were delays in acting on concerns raised.

Malcolm Ross M.Sc
Independent Chair/Author of Domestic Homicide Reviews

June 2018

List of Overview Report Recommendations

Recommendation No 1

Agencies making reference to a person's mental capacity should be precise as to what decisions the person can and cannot be deemed to have capacity to make especially where the person's safeguarding is involved.

Recommendation No 2

Cancellation of appointments by known vulnerable people should not be accepted on face value and should be checked and confirmed, especially when a family member is expressing concerns regarding the behaviour and demeanour of the vulnerable person.

Recommendation No. 3

All agencies should be aware of the need to consider calling for a multi-agency meeting with regard to those known vulnerable people who are regularly calling for assistance from a variety of agencies in circumstances when the calls are unnecessary or inappropriate.

Recommendation No 4

Northampton Partnership Homes should be aware of the need to make referrals to the police and /or social services where evidence of criminality is observed by NPH personnel in the course of their duty and should always be mindful that a safeguarding opportunity may be missed if such a referral is not made.

Recommendation No 5

Where issues of funding for accommodation arises Adult Social Services should take a leading role in the coordination of efforts to secure funding, which should be completed as soon as possible and not prolong a person's vulnerability in delaying the decision making process.

Individual Management Reviews Recommendations

Northampton County Council

Recommendation No 1

All parties who are entitled to, receive a copy of this report.

Recommendation No 2

The department to standardise supervision arrangements and embed the Supervision Policy to ensure that team meetings take place.

Recommendation No 3

The Department to roll out training to ensure that the Care Act and local guidance/policy have been embedded into local arrangements and day to day practice.

Recommendation No 4

The Department to devise and implement an Audit Framework that seeks to ensure that each tier of staff including management carry out frequent audits including peer audits.

Recommendation No 5

The Department to implement a mechanism to highlight cases that have been open to Adult Social Care for extended periods of time in order to trigger a holistic review of arrangements.

Recommendation No 6

The Department to carry out an internal investigation into the management of The Pending List.

Recommendation No 7

The Department to review the process used to categorise Pending List cases and ensure that staff are equipped and trained to effectively carry out an assessment of risk.

Recommendation No 8

The NSAB to ensure that their arrangements and assurance seeking mechanisms are robust and fit for purpose. There should be an effective Learning and Improvement Framework in place that is equipped to expose and indicate any potential and /or current risk.

Recommendation No 9

The NSAB to ensure and oversee the timely review and ratification of Policy Documents. The Department to consider rolling out training for staff to support staff awareness of NSAB, the interface between the Board and Local Arrangements, the role of the Board and how practitioners can act as a crucial source of information to the Board and the strategic decision making process.

Recommendation No 10

The Department to strengthen their processes to ensure that the DHR process is enabled to take place uninterrupted in a fair and transparent manner.

Northamptonshire Police

Recommendation No 1

Northamptonshire Police undertakes an awareness raising approach supported by relevant training for key roles to remind all staff the importance of submitting Form SA1 where appropriate including its operation within Niche.

Recommendation No 2

Northamptonshire Police develops a model to identify, problem solve and actively manage investigations where the victim(s) are vulnerable and reluctant to engage with the police beyond the initial report.

Northampton Partnership Housing

Recommendation No 1

Housing Officers and Support Workers to be given specialist training/awareness raising to consider “could this situation be domestic abuse?” in any situations of alleged abuse/violence.

Recommendation No 2

Support Officer DC to be asked about the lack of notes for this case and provided with required training. Support Manager to reiterate to wider team and provide training on the importance of following procedure putting notes on to say they are the support worker and recording notes and actions.

Recommendation No 3

Housing Officers and Support Officers to receive guidance/training on the importance of sharing intelligence and information.

Recommendation No 4

Procedure to be created for the call centre so when they take a call from someone saying they are at risk or unsafe in their property that all Team Leaders are emailed with the details, that the call is put through to the duty officer if available and if not that a call back is logged for the Housing Officer. This will ensure that the decision making doesn't sit with one person in terms of outcome.

Recommendation No 5

An investigation will be undertaken regards Support Worker VJ for not taking the appropriate action when the Victim called to say he was unsafe in September 2015. The resulting action taken will depend on whether through the DHR it can be ascertained had the Support Worker called the police, whether a move would have been sought.

Recommendation No 6

Procedure to be created for when someone contacts the Housing Officer to say they are unsafe or at risk e.g. must always take action- taking information and checking with the police and to record outcome on IBS. Training to be delivered to Housing Officers once procedure created.

Recommendation No 7

Create a procedure that in all cases where someone claims they are in danger or at risk or a third party makes the claim on their behalf, that they are referred to the serious case panel for consideration.

Recommendation No 8

NPH to provide training and increase awareness to Housing Officers that tenants can make homeless applications to other local authorities if at risk with support.

Recommendation No 9

Liaise with Contact Centre managers to ensure that when there is concerning information taken this is shared with Housing Officers.

Recommendation No 10

New procedure to be created when concern cards are received that the Housing Officer arranges a meeting/discussion with the person who submitted the card to ensure they have a full understanding of the situation.

Recommendation No 11

Procedure/guidance to be created for Housing Officers that when they receive information from a third party that someone is at risk they urge the person to contact other services such as social services and the police as other services may hold information they do not and direct dialogue with other services could extract further relevant information.

Recommendation No 12

A process for the recording and storing of letters to be devised and implemented.

Northamptonshire Healthcare NHS Foundation Trust

Recommendation No 1

For NCC Public Health and CCG commissioner to review the potential for current Drug and Alcohol pathways and consider how this is better integrated with Mental Health Services for future service delivery including options for full alignment and integration.

Northampton General Hospital

Recommendation No 1

The Trust should re-launch the multi-agency Adults At Risk (ARM) process in order to support those individuals for whom access to services is a challenge.

Recommendation No 2

The Trust should work in collaboration with the police to develop a clear protocol to support the effective safety planning of those who leave hospital where concerns for their welfare remain.

East Midlands Ambulance Service

Recommendation No 1

The individual staff members involved in the attendances for the Victim and the Perpetrator where there were missed opportunities to refer the patients to reflect on their practice.

Recommendation No 2

A communication piece will be shared in the EMAS E-News reminding staff of the importance of recognising Domestic Violence and Abuse (DVA) and offering victims referrals to supportive services. It will be highlighted that this needs to be documented.

Recommendation No 3

There is a level 2 safeguarding workbook containing information on DVA to be provided to all staff during February 2017. From April 2017 all staff will be required to complete an eLearning package and assessment around safeguarding and DVA. This will be used as a training needs analysis and themes will be pulled from this domestic homicide review and used in the assessment during 2017-2018.

Appendix No 1

A Domestic Homicide Review into the death of a man aged 55 years in June 2016

Purpose of a Domestic Homicide Review

The Domestic Violence, Crimes and Victims Act 2004, establishes at Section 9(3), a statutory basis for a Domestic Homicide Review, which was implemented with due guidance[1] on 13th April 2011 and reviewed in December 2016[2]. Under this section, a domestic homicide review means 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 house hold as himself, held with a view to identifying the lessons to be learnt from the death"*

Where the definition set out in this paragraph has been met, then a Domestic Homicide Review must be undertaken.

It should be noted that an intimate personal relationship includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

In March 2013, the Government introduced a new cross-government definition of domestic violence and abuse[3], designed to ensure a common approach to tackling domestic violence and abuse, by different agencies. The new definition states that domestic violence and abuse is:

> *"Any incident or pattern of incidents of controlling, coercive or 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. This can encompass, but is not limited to, the following types of abuse:*
> - *psychological*
> - *physical*
> - *sexual*
> - *financial*
> - *emotional*

Domestic Homicide Reviews are not inquiries into how a victim died or who is to blame. These are matters for Coroners and Criminal Courts. Neither are they part of any disciplinary process. The purpose of a DHR is to:

[1] Multi-Agency Statutory Guidance For The Conduct of Domestic Homicide Reviews - Home Office 2011 *www.homeoffice.gov.uk/publications/crime/DHR-guidance*
[2] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office 2016
[3] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised August 2013 Home Office now revised again by 2016 guidance.

- Establish what lessons are to be learned from the homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

- Apply these lessons to service responses including changes to the policies and procedures as appropriate; and

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

- Contribute to a better understanding of the nature of domestic violence and abuse : and

- Highlight good practice

Process of the Review

In compliance with Home Office Guidance[4], Northamptonshire Police notified the circumstances of the death in writing to Northampton Community Safety Partnership (NCSP).

On 10th March 2016 the Chair of the Northampton Community Safety Partnership advised the Home Office that the circumstances did meet the criteria for a Domestic Homicide Review and as such a review should be conducted under Home Officer Guidance as well as guidance from the NCSP.

Home Office Guidance[5] requires that DHRs should be completed within 6 months of the date of the decision to proceed with the review.

Independent Chair and Author

Home Office Guidance[6] requires that;

> *"The Review Panel should appoint an independent Chair of the Panel who is responsible for managing and coordinating the review process and for producing the final Overview Report based on IMRS and any other evidence the Review Panel decides is relevant", and "…The Review Panel Chair should, where possible, be an experienced individual who is not directly associated with any of the agencies involved in the review."*

NCSP decided in this case to appoint an independent chair and author.

[4] Home Office Guidance 2016 Page 9
[5] Home Office Guidance 2016 pages 16 and 35
[6] Home Office Guidance 2016 page 12

The Independent Author, Mr Malcolm Ross, was appointed at an early stage, to carry out this function. He is a former Senior Detective Officer with West Midlands Police and has many years' experience in writing over 26 Domestic Homicide Reviews and chairing that process. He has previously performed both functions in relation to over 80 Serious Case Reviews. Prior to this review process he had no involvement either directly or indirectly with the members of the family concerned or the delivery or management of services by any of the agencies. He has attended the meetings of the panel, the members of which have contributed to the process of the preparation of the Report and have helpfully commented upon it.

DHR Panel

In accordance with the statutory guidance, a DHR Panel was established to oversee the process of the review. Mr Ross chaired the Panel and also attended as the author of the Overview Report. Other members of the panel and their professional responsibilities were:

Job Title and Organisation
Women's Aid
Violence Against Women and Girls (VAWG) Coordinator, Northampton County Council Public Health & Well Being
Head of Safeguarding and Quality, Adult Social Care Services, Northampton County Council
Senior Independent Domestic Violence Advisor, Sunflower centre
Assistant Director Northamptonshire Partnership Homes
Safeguarding Clinical Lead, Northamptonshire Healthcare NHS Foundation Trust
Northamptonshire Police
Designated Nurse for Adult Safeguarding, Nene and Corby Clinical Commissioning Group
Lesbian, Gay, Bisexual and Transgender (LBGT) Forum
S2S
Safeguarding Project Officer, Integrated Business Office Northamptonshire County Council
Community Safety Officer Northampton Community Safety in Partnership
Senior Business Support Officer, Safeguarding Adults Board
Independent Chair and Overview Author

The Panel members confirm they had no direct involvement in the case, nor had line management responsibility for any of those involved. The Panel was supported by the DHR Administration Officer. The business of the Panel was conducted in an open and thorough manner. The meetings lacked defensiveness and sought to identify lessons and recommended appropriate actions to ensure that better outcomes for vulnerable people in these circumstances are more likely to occur as a result of this review having been undertaken.

Parallel proceedings

The Panel were aware that the following parallel proceedings were being undertaken:

- NCSP advised HM Coroner on 10th November 2016, that a DHR was being undertaken.

- Criminal proceedings had been commenced and this review was aware of the rules of disclosure.

Time Period

The time period for the review is from 1st January 2013 to the date of the Victim's death in June 2016.

Scoping the Review

The process began with an initial scoping exercise prior to the first panel meeting. The scoping exercise was completed by the NCSP to identify agencies that had involvement with the Victim and Perpetrator prior to the homicide. Where there was no involvement or insignificant involvement, agencies were requested to inform the Review by a report.

Individual Management Reports

Individual Management Reports (IMR) and comprehensive chronology was received from the following organisations:

- East Midlands Ambulance Service
- Primary Care including GPs
- Headway Northampton
- Northampton General Hospital
- Northampton Health Foundation Trust
- Northampton Partnership Housing
- Northampton County Council
- Northamptonshire Police
- S2S

In addition reports were received from:

- Aidcare
- IC24

Guidance[7] was provided to IMR Authors through local and statutory guidance and through an author's briefing. Statutory guidance determines that the aim of an IMR is to:

- Allow agencies to look openly and critically at individual and organisational practice and the context within which professionals were working (culture, leadership, supervision, training, etc.) to see whether the homicide indicates that practice needs to be changed or improved to support professionals to carry out their work to the highest standard.
- To identify how those changes will be brought about.
- To identify examples of good practice within agencies.

Agencies were encouraged to make recommendations within their IMRs and these were accepted and adopted by the agencies that commissioned the reports. The recommendations are supported by the Overview Author and the Panel.

The IMR Reports were of a high standard providing a full and comprehensive review of the agencies' involvement and the lessons to be learnt.

[7] Home Office Guidance 2016 Page 20

The Panel members confirm they had no direct involvement in the case, nor had line management responsibility for any of those involved. The Panel was supported by the DHR Administration Officer. The business of the Panel was conducted in an open and thorough manner. The meetings lacked defensiveness and sought to identify lessons and recommended appropriate actions to ensure that better outcomes for vulnerable people in these circumstances are more likely to occur as a result of this review having been undertaken.

Terms of Reference for the Review

The aim of the DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

- Identify clearly what the those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

- Apply these lessons to service responses including changes to the policies and procedures as appropriate;

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

- Contribute to a better understanding of the nature of domestic violence and abuse : and

- Highlight good practice

Process

An Independent Chair/Author has been commissioned to manage the process and compile the report. Membership of the Domestic Homicide Review Panel will include representatives from relevant agencies.

Individual Needs

Home Office Guidance[8] requires consideration of individual needs and specifically:

> 'Address the nine protected characteristics under the Equality Act 2010 if relevant to the review. Include examining barriers to accessing services in addition to wider consideration as to whether service delivery was impacted'

Section 149 of the Equality Act 2010 introduced a public sector duty which is incumbent upon all organisations participating in this review, namely to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

[8] Home Office Guidance 2016 page 36

- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The review gave due consideration to all of the Protected Characteristics under the Act.

The Protected Characteristics are: age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

There was nothing to indicate that there was any discrimination in this case that was contrary to the Act.

Family Involvement

Home Office Guidance[9] requires that:

> "Consideration should also be given at an early stage to working with family liaison officers and senior investigating officers involved in any related police investigation to identify any existing advocates and the position of the family in relation to coming to terms with the homicide."

The 2016 Guidance[10] illustrates the benefits of involving family members, friend and other support networks as:

> a) assisting the victim's family with the healing process which links in with Ministry of Justice objectives of supporting victims of crime to cope and recover for as long as they need after the homicide;
>
> b) giving family members the opportunity to meet the review panel if they wish and be given the opportunity to influence the scope, content and impact of the review. Their contributions, whenever given in the review journey, must be afforded the same status as other contributions. Participation by the family also humanises the deceased helping the process to focus on the victims and perpetrator's perspectives rather than just agency views.
>
> c) helping families satisfy the often expressed need to contribute to the prevention of other domestic homicides.
>
> d) enabling families to inform the review constructively, by allowing the review panel to get a more complete view of the lives of the victim and/or perpetrator in order to see the homicide through the eyes of the victim and/or perpetrator. This approach can help the panel understand the decisions and choices the victim and/or perpetrator made.
>
> e) obtaining relevant information held by family members, friends and colleagues which is not recorded in official records. Although witness statements and evidence given in court can be useful sources of information for the review, separate and substantive interaction with families and friends may reveal different information to that set out in official documents. Families should be able to provide factual information as well as testimony to the emotional effect of the homicide. The review panel should also be aware of the

[9] Home Office Guidance 2016 page 18
[10] Home Office Guidance 2016 Pages 17 - 18

risk of ascribing a 'hierarchy of testimony' regarding the weight they give to statutory sector, voluntary sector and family and friends contributions.

f) revealing different perspectives of the case, enabling agencies to improve service design and processes.

g) enabling families to choose, if they wish, a suitable pseudonym for the victim to be used in the report. Choosing a name rather than the common practice of using initials, letters and numbers, nouns or symbols, humanises the review and allows the reader to more easily follow the narrative. It would be helpful if reports could outline where families have declined the use of a pseudonym.

In this case the Overview Report Author made contact with the Senior Investigating Officer (SIO) from South Wales Police at an early stage.

Comments made by the family members have been included and referred to in this report. Please see section 'Views of the Family'.

A letter inviting the Perpetrator to contribute to this review was sent to him and his solicitor whilst P was in HM Prison on remand. He has not acknowledged the letter or indicated that he wishes to be seen as part of the review. He has not replied to a request for the review to have access to his medical records.

Family members have been supplied with a redacted copy of the Overview report and the Executive Summary of this report.