OVERVIEW REPORT

DOMESTIC HOMICIDE REVIEW

in respect of

VICTIM 2 – 2014
Deceased May 2014
Age 48 years

Chris Few
November 2015

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INTRODUCTION

1.1 Domestic Homicide Reviews were introduced by the Domestic Violence, Crime and Victims Act (2004), section 9.

1.2 A duty on a relevant Community Safety Partnership to undertake Domestic Homicide Reviews was implemented by the Home Office through statutory guidance in April 2011. The 'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews' was updated in August 2013 and that revision provided the framework within which this Review was conducted[1].

1.3 A Domestic Homicide Review (DHR) is defined[2] as:

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 person to whom he was related or with whom he was or had been in an intimate personal relationship, or
- a member of the same household as himself,

held with a view to identifying the lessons to be learnt from the death.

1.4 The purpose of a 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 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 policies and procedures as appropriate; and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

1.5 DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for Coroners and criminal courts. They are also not specifically part of any disciplinary enquiry or process; or part of the process for managing operational responses to the safeguarding or other needs of individuals. These are the responsibility of agencies working within existing policies and procedural frameworks.

[1] www.homeoffice.gov.uk.
[2] Domestic Violence, Crime and Victims Act (2004), section 9(1).

2 Summary of Circumstances Leading to the Review

2.1 The victim (P) and perpetrator (Q) were in an intimate relationship for around 5 years and lived together.

2.2 In May 2014 West Midlands Ambulance Service and Staffordshire Police went to the address shared by P and Q following a call from Q to the effect that a man had fallen and was unconscious. P, who had numerous injuries, went into cardiac arrest as the Police arrived and attempts to resuscitate him were unsuccessful. He was confirmed dead shortly after his arrival at hospital.

2.3 Q was arrested and subsequently charged with the murder of P.

2.4 On 24 June 2014 a Scoping Panel convened on behalf of the Stoke-on-Trent Responsible Authorities Group considered the circumstances of the case and concluded that the criteria for conducting a Domestic Homicide Review were met. A recommendation to commission a Domestic Homicide Review was endorsed by the Chair of the Responsible Authorities Group on 8 July 2014.

2.5 Q subsequently pleaded guilty to the murder of P and was sentenced to life imprisonment.

3 Terms of Reference

3.1 The full Terms of Reference for this Review are at Appendix A. The following is a summary of the key points.

3.2 The Review considered in detail the period from 1 January 2009 until the date of P's death, to cover the period that the he was known to have been in a relationship with Q. Summary information regarding significant events outside of this period was also considered.

3.3 The focus of the Review was on the following individuals:

Name	P	Q
Relationship	Victim	Perpetrator
Age	48	45
Gender	Male	Male
Ethnicity	White British	White British

3.4 Specific issues considered by the Review were:

- Domestic abuse against the victim, knowledge of and response to this by agencies and why no service for victims of domestic abuse was sought or provided; with particular consideration of;
  a. the availability and accessibility of relevant services, and
  b. the impact of the victim's and perpetrator's lifestyle[3], their extended families and the community within which they lived

[3] To include his sexuality and how this was viewed by the community.

- Domestic abuse by the perpetrator, knowledge of and response to this by agencies and why no service for perpetrators of domestic abuse was provided; including particular consideration of;
  a. the availability and accessibility of relevant services, and
  b. the impact of the perpetrator's lifestyle, his extended family and the community within which he lived.
- Alcohol misuse by the victim and perpetrator, and the effectiveness of related services
- Mental health of the victim and perpetrator, and the effectiveness of related services.

4 Review Panel Chair and Independent Overview Report Author

4.1 The Review Panel was chaired and this report of the Review was written by Chris Few, an Independent Consultant. Mr Few has chaired review panels and written overview reports on behalf of numerous Community Safety Partnerships, Local Safeguarding Children Boards and Local Authorities in connection with Domestic Homicide Reviews and Serious Case Reviews[4]. He has no professional connection with any of the agencies and professionals involved in the events considered by this Review.

5 Review Panel Members

5.1 The Review Panel comprised the following post holders:

- Area Manager
  Aquarius

- Domestic Abuse Service Manager (as an advisor to the Panel)
  Arch

- Lead Nurse Adult Safeguarding
  North Staffordshire and Stoke-on-Trent Clinical Commissioning Groups
  (On behalf of NHS England)

- Named Nurse for Safeguarding
  North Staffordshire Combined Healthcare NHS Trust

- Senior Investigating Officer
  Staffordshire Police

- Detective Sergeant
  Investigative Services Policy, Review and Development Unit
  Staffordshire Police

- Personal Crime Programme Lead
  Stoke-on-Trent City Council

- Safer City Partnership Manager and Alcohol Lead
  Stoke-on-Trent City Council

- Operational Lead for the Rebalance Me Project / Tenancy and Estate Management Intervention

[4] Under the Children Act (2004) and its associated statutory guidance.

Stoke-on-Trent City Council

- Senior Nurse Safeguarding
  University Hospitals of North Midlands NHS Trust (formerly University Hospital of North Staffordshire NHS Trust)
- Safeguarding Manager
  West Midlands Ambulance Service NHS Trust.

6 Review Process

6.1 The Review Panel met on two occasions to consider contributions to and emerging findings of the Review:

- 16 September 2014
- 3 March 2015.

6.2 Processes internal to Staffordshire Police delayed provision of their final report to the Review and consequently the completion of the Review. This Overview Report was endorsed by the Review Panel on 1 December 2015 and forwarded to the Chair of the Stoke-on-Trent Responsible Authorities Group. It was subsequently presented to and endorsed by the Responsible Authorities Group on 2 February 2016.

7 Contributions to the Review

7.1 Requests to confirm the extent of their involvement with the subjects of this Review were sent to all statutory and voluntary agencies in Stoke-on-Trent and Staffordshire who may potentially have had such involvement. This scoping process was used as the basis for more targeted requests for Management Review and Summary Information Reports.

7.2 Management Review and Summary Information Reports were submitted by:

- Aquarius
- NHS England (Primary Care Services)
- North Staffordshire Combined Healthcare NHS Trust
- Staffordshire Police
- Stoke-on-Trent City Council
- University Hospitals of North Midlands NHS Trust (formerly University Hospital of North Staffordshire NHS Trust)
- West Midlands Ambulance Service NHS Trust.

7.3 Q refused a request for access to his primary health care records to inform the Review[5]. Access to those records by the Review Panel may have provided access to information regarding mental health treatment mentioned by Q when in contact with agencies during the review period and would very probably have improved the Review Panel's understanding of what occurred and the reasons for that.

7.4 Other sources of information accessed to inform the Review included:

[5] GP's are not subject to the statutory guidance under the Domestic Violence, Crime and Victims Act (2004). Notwithstanding the impact of this on Domestic Homicide Review processes, Stoke-on-Trent is currently implementing enhanced arrangements to promote the referral by GPs of their patients as either victim or perpetrator to relevant domestic abuse services.

- An overview of domestic violence and abuse services in Stoke-on-Trent prepared by the City Council Personal Crime Programme Lead
- NICE Public Health Guidance 50 - Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively (February 2014)
- Reducing the impact of Violence - draft Scoping Document, Association of Directors of Public Health (West Midlands). (November 2014)
- Stoke-on-Trent Domestic Abuse Partnership and Staffordshire Domestic Abuse Steering Group Best Practice Guidelines "Working with male victims of domestic abuse in Staffordshire and Stoke-on-Trent" (September 2014).

8 Parallel Processes

8.1 The criminal investigation into the murder of P was conducted in parallel with this Review.

8.2 During the criminal investigation three family members/friends of Q were arrested for witness intimidation. There were no further incidents and at the time of Q's trial the Crown Prosecution Service decided not to pursue prosecutions for this.

8.3 HM Coroner for Stoke-on-Trent and North Staffordshire opened and adjourned an inquest pending the outcome of the criminal trial. Consequent to Q's conviction the inquest was not resumed.

8.4 Aquarius conducted a 'Serious Untoward Incident Investigation' in parallel with and informing their contribution to this Review. Consequent to this internal performance management processes, were followed in respect of the case workers involved. All three staff members who led on the response to Q are no longer employed by Aquarius.

8.5 Staffordshire Police, as consequence of information collated through this Review, initiated a disciplinary investigation in relation to Police Officers' actions in August 2013.

9 Family Engagement

9.1 Members of P's family and Q's parents were advised of the Review at its outset. Letters inviting family members to contribute to the review were hand delivered by the Police Family Liaison Officer. They all responded that they did not want to meet with the Chair of the Review or contribute in any other way. Further that they did not want to see the report or have any other involvement with the Review.

9.2 Q was also informed of the Review at its outset. He was invited to contribute and asked for consent to access his primary care medical records. He declined in both respects.

9.3 Notwithstanding the views expressed by those invited to contribute to the Review, they were again offered sight of this report on its completion and prior to its submission to the Home Office.

ORGANISATIONAL CONTEXT

10 Stoke-on-Trent Profile

10.1 The unitary authority of the City of Stoke-on-Trent lies within the county of Staffordshire. It became a unitary authority in 1997.

10.2 According to the English Indices of Deprivation 2015, Stoke-on-Trent is the 3rd most deprived local authority in the West Midlands (out of 33) and the 14th most deprived local authority in England (out of 326).

10.3 The 2011 census recorded the population of Stoke-on-Trent as 249,000, residing in 107,000 households. There were 124,000 males, (49.8%) and 125,000 females, (50.2%).

10.4 86.4% described themselves as White British, 7.4% as Asian or Asian British and 1.5% as Black or Black British.

11 Local Strategic Context

11.1 The Stoke-on-Trent City Council Strategic Plan 2016-2000 "Stronger Together sets out the Council's vision 'Working together to create a stronger city we can all be proud of'. Provision of services for high risk victims of domestic violence and abuse contributes to this vision.

11.2 The Stoke-on-Trent Joint Health and Wellbeing Board Strategy 2013-2016 prioritises reducing the negative impact of domestic abuse. It is recognised that the cost of domestic abuse to the public sector is high and that the experience of domestic abuse on victims and their children is devastating.

11.3 Stoke-on-Trent's Safer City Partnership delivers the national crime, disorder and substance misuse strategies at a local level. The Safer City Partnership Plan 2014-17 identifies violent crime, including domestic abuse, as a priority for the City.

11.4 The Stoke-on-Trent Domestic Abuse Partnership has been in place since 2008 and reports directly to the Safer City Partnership's Responsible Authorities Group, the Local Safeguarding Children Board and the Children and Young People's Strategic Partnership Board. Membership consists of statutory sector, third sector and community group representatives.

11.5 In order to support the national priorities at a local level, the Domestic Abuse Partnership has the following priorities in their Domestic Abuse Strategy for 2013-16:

- Prevention – increase awareness and change attitudes, especially in young people
- Provision of Services – access to specialist support for victims, children and young people
- Partnership Working – co-ordinated actions are in place to enable partners to deliver services efficiently, effectively and in a cost effective way
- Justice Outcomes and Risk Reduction – ensure victims are fully supported through the court process, partners are signed up to the domestic homicide review process and perpetrators are informed about voluntary programmes.

11.6 Staffordshire Criminal Justice Board Victims and Witnesses sub-group receives performance information concerning, inter alia, domestic violence and abuse, with actions identified and implemented for service improvements.

11.7 This group, together with the Domestic Abuse Partnership, receives feedback from victims of domestic violence and abuse regarding Criminal Justice Services to inform the identification and implementation of service improvements.

12 Incidence / Impact of Domestic Violence and Abuse in Stoke-on-Trent

12.1 Based on national research 1 in 4 women and 1 in 6 men experience domestic violence and abuse at some point in their lives. This means that Stoke-on-Trent, with a population of 249,000, potentially has 31,250 women and 20,666 men in the City who will at some time experience domestic violence and abuse.

12.2 The Joint Strategic Needs Assessment 2010-2015 (JSNA) reports that domestic abuse continues to be a major cause of family distress and social exclusion[6] and accounts for around a quarter of all reported violent crime in Stoke-on-Trent.

12.3 Whilst the information is not directly comparable, data for the Staffordshire Police area as a whole provides an indication of the incidence of domestic violence and abuse crimes relevant to this Review.

12.4 In 2013-14 8237 domestic violence crimes were reported a slight increase on the previous year. Of these approximately 18% involved male victims with this number including 149 (1.8% of the total) where the male victim was in a same sex relationship.

12.5 Data suggests that the reported incidence of domestic violence and abuse towards men is increasing. In 2013-14 the number of male high risk victims referred to MARAC had increased by 23% over the total for the previous year and the incidence of domestic violence reports involving male victims in same sex relationships also increased by 23% from 2013-14 to 2014-15.

13 Domestic Violence and Abuse Services in Stoke-on-Trent

13.1 In August 2013 Stoke-on-Trent City Council awarded a three year contract to Arch (North Staffs Ltd.) to provide the following domestic violence and abuse services for men, women and children:

- Julia House - a purpose built refuge for women and children who have been subject to, or are at risk of, domestic abuse
- A local telephone helpline
- An outreach service, including one to one practical and emotional support for women and children (and a small number of men)
- Counselling by trained counsellors
- Tailored support to individuals whose spouse or partner is attending a perpetrator programme
- Personal safety advice and support including the installation of security equipment where appropriate
- A school based educational project, providing children and young people the opportunity to explore and understand the effects abusive and/or controlling relationships have and educate children and young people around relationships

[6] The percentage of customers presenting as homeless due to domestic violence and abuse (11-13%) is the fourth highest reason for homelessness in Stoke-on-Trent.

- A domestic abuse recovery programme (RISE) working with children, young people and their mothers recovering from living with domestic violence and abuse. The programme takes place over 10 weeks with groups for children, young people and their mothers running in parallel to each other
- An accredited perpetrator programme.

13.2 Additional services which are provided within the City outside of this contract include:

- The Freedom Programme - A 12-week course open to any woman who wants to learn more about the realities of domestic abuse. It is designed to empower women, increase their self-confidence and help to improve the quality of their live.
- Sunrise Centre - The Sunrise Centre is a safe and welcoming service for women, men, young people and children who have survived domestic abuse
- Training Programmes - educating professionals about the issues surrounding domestic violence and abuse
- Practical and emotional support for men and women by an Independent Domestic Violence Advisor (IDVA), who supports victims before, during and after the court process
- A target hardening scheme provided by Revival, which provides low level measures to help people feel safe within their home.

13.3 Specialist Domestic Violence Courts

13.3.1 During 2006 North Staffordshire (Newcastle-under-Lyme) Magistrates Court became one of 64 areas[7] to be accredited with specialist domestic violence court (SDVC) status. Cases are heard from Stoke-on-Trent, Newcastle-under-Lyme and Staffordshire Moorlands.

13.3.2 These court systems are part of the Government's efforts to improve the support and care provided for victims of domestic violence and abuse. The specialist domestic violence court programme promotes a combined approach to tackling domestic violence by the Police, the Crown Prosecution Service (CPS), Magistrates, Courts and Probation together with specialist support services for victims as part of a community-wide response to domestic violence. During 2010/11 there were 726 domestic violence cases heard at Newcastle-under-Lyme Magistrates Court. This nearly doubled to 1318 in 2011/12 and 1250 in 2012/13. The conviction rate for prosecuted offences was 65% for 2010/11, 73% for 2011/12 and 70% in 2012/13.

13.3.3 Each SDVC should have Independent Domestic Violence Advisors (IDVA) who have attended accredited training to provide support for service users and whose goal is the safety of their service users and their children. There are currently 4 IDVAs employed by Stoke-on-Trent City Council who fulfil these responsibilities.

13.4 Stoke-on-Trent Domestic Abuse Partnership Achievements

13.4.1 In addition to the development and strategic oversight of the services mentioned above, between 2011 and 2013 the Stoke-on-Trent Domestic Abuse Partnership:

- Undertook a number of comprehensive media campaigns to encourage the reporting of domestic violence and abuse. Examples included campaigns that were held during the 2012 European Football Cup competition and during the weeks leading up to Valentine’s Day in February 2013

[7] There are now over 100 specialist courts nationally.

- Jointly hosted with Newcastle-Under-Lyme Safer Communities Partnership and ARCH North Staffordshire the fourth Annual North Staffordshire Domestic Violence Conference in November 2012, entitled 'Prevention, not Cure'. This was attended by around 100 delegates and highlighted developments in perpetrator work both nationally and locally
- Trained 25 officers from across the Partnership to enable them to act as facilitators within the RISE group work recovery programme
- Following a review of Stoke-on-Trent City Council Housing Services Sanctuary scheme, it was decided that more people could be protected by providing lower-level measures to customers experiencing, or at risk of, domestic abuse. A target hardening service was put out to tender, and was awarded to the Revival Home Improvement Agency in April 2103.

13.4.2 More recently, in September 2014, the Stoke-on-Trent Domestic Abuse Partnership with Staffordshire Domestic Abuse Steering Group produced Best Practice Guidelines "Working with male victims of domestic abuse in Staffordshire and Stoke-on-Trent" in response to learning from an earlier Domestic Homicide Review. This guidance is intended to:

- Raise practitioners' awareness of male victims of domestic abuse and violence
- Raise awareness of the services that are available in every district of Staffordshire to support male victims of domestic abuse
- Provide practitioners with the information they need to respond safely and appropriately to male service users following a disclosure of domestic abuse; and
- Highlight sources of support and guidance (for both the service user and the practitioner).

13.4.3 Notwithstanding the breadth of services being provided it has been identified that more could be done in the following areas:

- Early intervention and prevention support with key workers dedicated to supporting victims at the earliest opportunity therefore reducing the number of victims reaching crisis point
- Support for victims attending court who do not meet the MARAC threshold or who are not supported by IDVAs
- Specialist support for young people aged 16 and 17 who have suffered abuse. Young people aged 16-17 were recently included in the government definition of domestic violence and abuse and there has been steady rise in referrals for this age group
- A specific age appropriate perpetrator programme for young people aged between 11 and 20 who are perpetrating violence on family members and/or partners
- Specialist support for South Asian women and victims of forced marriage.

13.5 Locality Partnership Working.

13.5.1 In 2014 locality based partnership working arrangements were implemented across Stoke-on-Trent with the aim of improving information sharing, cooperation and joint working within a multi-agency response. Partners within this approach include the City Council Housing, Staffordshire Police, Aquarius, Crime Reduction Initiative (CRI), Probation and Adult Safeguarding Team.

13.5.2 Work to address a range of community safety issues, including domestic abuse, is ongoing daily but is further coordinated through fortnightly Vulnerability Hub meetings where additional interventions are identified and progress with them monitored.

13.5.3 The Police, Stoke-on Trent City Council and Aquarius reports all make reference to these arrangements as a positive development which has promoted good practice.

14 Key Agency Context

14.1 Arch

14.1.1 Arch is a registered charity that, since 1989, has been providing a diverse range of services for children, young people, adults and families in local communities across Stoke-on-Trent, Staffordshire and more recently Cheshire East. Each year Arch works with over 3000 people who are in housing need or crisis, including but not solely victims and perpetrators of domestic violence and abuse.

14.1.2 The Arch Domestic Violence Outreach Service has historically offered a range of interventions to survivors and perpetrators of domestic violence; including a service to male victims which were first commissioned in 2010.

14.1.3 Referrals come from a range of agencies with a significant proportion made by the MASH (Multi-Agency Safeguarding Hub). Self-referrals are also accepted.

14.1.4 The interventions delivered by the Domestic Violence Outreach Service include one to one and group work interventions delivered to female, male and child victims of domestic abuse and a 30 week group programme which is delivered to male perpetrators on a rolling basis.

14.1.5 On a pilot basis Arch provided a LGBT support worker for nine months in 2013-14. That worker found it very difficult to secure engagement from victims and during that period only one person identified themselves as being in a non-heterosexual relationship.

14.1.6 While relevant services were available to them, neither P nor Q had any involvement with Arch.

14.2 Aquarius

14.2.1 Stoke-on-Trent Community Alcohol Service was (until October 2015[8]) provided by Aquarius which supported anyone with a concern about drinking,

14.2.2 Aquarius offered:

- Advice and information for people misusing alcohol and people concerned about someone else's drinking
- Assessment of drinking levels
- Structured one-to-one support for people who are committed to changing their drinking behaviour
- Referral for medical treatment and/or detoxification where needed
- Referral to structured daycare and/or residential rehabilitation where needed
- Diversionary activities to help people achieve and maintain their goals.

14.2.3 Following a self-referral Q was in contact with Aquarius from July 2013 to January 2014

14.3 North Staffordshire Combined Healthcare NHS Trust

14.3.1 North Staffordshire Combined Healthcare NHS Trust (NSCHT) provides mental health, substance misuse and learning disability services to the population of Stoke-on-Trent, Newcastle-under-Lyme and Staffordshire Moorlands.

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[8] The service has now been re-commissioned from Lifeline.

14.3.2 The Access Team is a single point of contact and access for all NSCHT services. It incorporates all former Single Point of Access teams and the Crisis Resolution Home Treatment Team and operates 8am to 8pm Monday – Friday and 9am to 5pm at weekends (with crisis cover available outside of these hours).

14.3.3 This service now provides:

- Teams of qualified Health and Social Care Staff who work together to provide an assessment, advice and sign posting service to support recovery and promote well-being
- Support for people with mental health problems who are experiencing severe difficulties when the stability of their mental health has been interrupted by crisis
- Short term crisis intervention and/or home treatment to people to reduce the likelihood of them being admitted to mental health inpatient facilities
- Work to enable earlier discharge from inpatient care and ensures that all admissions are appropriate and that where possible, the person does not become admitted.

14.3.4 The Team operates an open referral system, which means if you are concerned about your mental health or someone you care for you can contact the team direct. They also take referrals from other professional groups for example General Practitioners, Heath Visitors, A&E and Police.

14.3.5 NSCHT did not have a trust-wide policy in place regarding domestic abuse until December 2013 when a Policy Framework was ratified by the NSCHT Trust Board. Consequent to this NSCHT commissioned Domestic Abuse Awareness Training from Arch which commenced in April 2014.

14.4 Staffordshire Police

14.4.1 Staffordshire Police provide policing services for Staffordshire and Stoke-on-Trent.

14.4.2 All front line police officers in Staffordshire undertake mandatory training on recognising and responding to domestic violence and abuse and to mental health issues. Mental health professionals are available in custody suites to support detainees with mental health problems. Arrangements are also in place for referral of detained individuals to alcohol misuse services.

14.5 Stoke-on-Trent City Council

14.5.1 Stoke-on-Trent council housing is managed by a division of the City Council, with day to day management undertaken by staff based locally.

14.5.2 The property let on a secure tenancy to Q from 1993, and later also occupied by P, is in a Stoke-on-Trent City Council housing estate comprising approximately 2,000 council tenancies.

14.5.3 Council tenants have a Tenancy Agreement which covers a range of rights and responsibilities for both the Tenant and the Council as their Landlord. The role of the Housing Officer is to ensure compliance with tenancy conditions which include condition of property and gardens, issues involving anti-social behaviour and rent arrears. Low level support will also be provided; however, for tenants with complex needs a referral for support will be made to the Community Support team. Each Housing Officer manages a number of dwellings (normally in the range of 350 to 500).

14.5.4 The role of the Community Support Officer is to provide support, advice and identify other service providers to meet any complex needs. This requires regular home visits, assistance in accessing services (e.g. GP's, DWP, alcohol support, mental health teams), assisting in the completion of application forms and other documentation. The long term aim of this service is to enable people to live independently. This support can be on-going for extended periods of time.

14.5.5 Both Housing Officers and Community Support Officers receive basic training in how to identify and respond to issues of domestic violence and abuse.

14.5.6 If council officers become aware of domestic violence they are responsible for completing a risk assessment and making referrals to other agencies as appropriate including Arch and to the MARAC.

14.5.7 The City Council is part of the locality based partnership working arrangements referred to above. Within this initiative the Council is embarking on a new delivery structure for services, called "Cooperative Working" to ensure that tenants and residents can access all relevant services ("tell my story once"), leading improved social, health and financial outcomes and ensuring that the most vulnerable are protected. The City Council report appropriately recommended that all relevant staff within the "Cooperative Working" model have up to date training in how to identify and respond to domestic violence and abuse.

14.5.8 Perpetrating domestic violence is a breach of tenancy conditions but in this case violence was not brought to the attention of the housing staff either directly or through a referral to MARAC.

14.5.9 If P had requested re-housing in order to escape domestic violence accommodation appropriate to his situation was and is available in Stoke-on-Trent.

14.6 **West Midlands Ambulance Service NHS Trust**

14.6.1 The Trust provides Ambulance Services across the West Midlands including Stoke-on Trent.

14.6.2 Domestic Abuse is included in the Trust's Adult Safeguarding Policy. A stand-alone Domestic Abuse Policy is currently being developed to further detail WMAS responsibilities for Domestic Abuse. Domestic Abuse sessions formed part of the 2014-2015 mandatory training programme for all front line staff, with a 99.97% completion rate. Since April 2014 WMAS has made domestic abuse referrals directly to the Police via the 24 hour safeguarding referral-line available to all staff.

14.7 **University Hospitals of North Midlands NHS Trust** (formerly University Hospital of North Staffordshire NHS Trust)

14.7.1 University Hospitals of North Midlands NHS Trust (UHNM) provides a full range of general acute hospital services for approximately half a million people living in and around North Staffordshire. In Stoke-on-Trent this is through the Royal Stoke Hospital. The Trust also provides specialised services for three million people in a wider area, including neighbouring counties and North Wales

14.7.2 Since 2012 the Trust has been developing and strengthening services and policies to increase staff awareness of domestic violence and abuse particularly within emergency settings. In April 2012 Public Health arranged a Service Level Agreement with Arch to

provide a temporary service to the Emergency Department. This service has proved to be very successful but is not a permanent solution.

14.7.3 Full implementation of a trust-wide policy for responding to domestic violence and abuse is coming to fruition to reflect processes at both Hospital sites. Arch does not cover County Hospital and therefore alternative processes for patients presenting at its site are under discussion.

14.7.4 In August 2011 an Alcohol Liaison Nurse post was established; with two additional Nurses being appointed in March 2012. These staff members operate across the whole hospital including within the Emergency Department to offer support and refer on to appropriate agencies. All clinical areas have a toolkit which contains advice for patients and forms for referral to the Alcohol Liaison Nurses. Whilst all professional staff may refer patients to alcohol misuse services such as Aquarius they generally do so through the Alcohol Liaison Nurses.

14.7.5 Prior to 2013 hard copies of Emergency Department notes were stored both on and off site. Since April 2013 the Emergency Department has implemented real time scanning of patients Emergency Department notes in order that they are available electronically for clinicians to review in a timely manner.

THE FACTS

15 Background of the Victim and Perpetrator

15.1 **P**

15.1.1 P was born, one of eight siblings, in Stoke-on-Trent where he lived for his whole life. He was in local authority care from the age of 7 until he was 15; when he returned to the care of his parents.

15.1.2 P never worked and as an adult he relied heavily on alcohol, with medical records indicating that this started when he was 15 years old. For many years P begged for money from his family, stating that it was for gas or electricity and his family reluctantly provided him with money in the knowledge that it would be used for purchasing alcohol.

15.1.3 P was never married and had no children.

15.1.4 P first came to the attention of Staffordshire Police in 1976, when at the age of eleven, he was convicted of burglary. From that time he had numerous convictions for burglary and theft related offences. He received his first drink related conviction in June 2000 and from that time the vast majority of his offending behaviour was due to drunkenness, with his final drink related conviction being in 2009.

15.1.5 P was known to North Staffordshire Combined Healthcare NHS Trust services during 1998-9, when, following a referral from his GP, he was diagnosed as having alcohol dependence syndrome, with a further provisional diagnosis of dissocial personality disorder[9]. There is no further mention of this in his medical records.

15.1.6 He was offered treatment to address his alcoholism at that time and subsequently but did not attend the appointments offered and refused to engage with services.

15.2 **Q**

15.2.1 Q was born, one of six siblings, in Stoke-on-Trent.

15.2.2 He had a previous relationship from which he has a son, born in 1997.

15.2.3 Q received his first conviction for a theft related offence in 1993 and another one in 1999.

15.2.4 Q first became known to North Staffordshire Combined Healthcare NHS Trust services in 2005 following a referral from his GP for an alcohol detoxification assessment. He declined an admission at this point. The GP made two further referrals, in 2006 and 2007, however Q again declined the services offered.

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[9] In order to meet the definition of dissocial personality disorder, an individual must exhibit at least three of the following traits:

1. a callous unconcern for the feelings of others;
2. a gross and persistent attitude of irresponsibility and disregard for social norms, rules and obligations;
3. an incapacity to maintain enduring relationships, though having no difficulty in establishing them;
4. a very low tolerance to frustration and a low threshold for discharge of aggression, including violence;
5. an incapacity to experience guilt or to profit from experience, particularly punishment; and
6. a marked proneness to blame others, or to offer plausible rationalizations, for the behaviour that has brought the patient into conflict with society.

This is not normally a treatable condition and further intervention following a provisional diagnosis would not be normal.

15.2.5 Whilst Q came to the notice of the Police for alcohol related matters he does not have any convictions for violence and any propensity for this did not come to light to the Police, or any other agency, until 2010 (see 16.8).

15.2.6 A property in a Stoke-on-Trent City Council housing estate was let to Q on a Secure Tenancy from February 1993.

15.3 Relationship between Q and P

15.3.1 The first record of P and Q residing together is from June 2009 when they were both taken to Q's home by the Police after they were found drunk.

15.3.2 Prior to July 2009 P came to the attention of the Police for drunkenness on numerous occasions. From then onwards drink related incidents involving P were minimal and it is clear that his continued abuse of alcohol was mainly confined to his home address where on many occasions he was noted by professionals and others to be very drunk.

15.3.3 Evidence gathered from friends and relatives during the homicide investigation indicates that by May 2010, when they had further contact with the Police, Q and P were in an intimate relationship. Neither was openly gay but there is conversely no indication that they ever attempted to hide the nature of their relationship. Neither appears to have discussed this with their friends and relatives and while it seems to have been implicitly acknowledged by some, it is clear that others within the community, including some family members, were less certain or even unaware of the relationship.

15.3.4 The first formal acknowledgment by P and Q that they were intimate partners was in August 2013 when they informed Stoke-on-Trent City Council of this. Even then the underlying motivation appears to have been the financial expediency of making a joint benefit claim and avoiding liability for the 'Spare Room Subsidy'.

16 Summary of Events

16.1 From the beginning of 2009 there were a number of tenancy breaches by Q in respect of his home address, including overgrown gardens, anti-social behaviour and rent arrears. These breaches were dealt with by the Stoke-on-Trent City Council Housing Officer. Over a period of time satisfactory resolutions were achieved and no further tenancy enforcement actions were deemed necessary.

16.2 Q referral for mental health assessment: June 2009

16.2.1 On 1 June 2009 Q was referred to the North Staffordshire Combined Healthcare NHS Trust Single Point of Access Service by his GP for an assessment of his mental health, following presentation at his GP practice complaining of mood variation and agitation with a request for a prescription for Diazepam[10], which the GP declined to provide. "Problem drinking" was also identified in the referral letter. Two appointments were offered in June 2009; neither of which were attended by Q. The GP was informed of the non-attendance and a letter was sent to Q advising him that he could self-refer to the Single Point of Access Service if required.

[10] Diazepam is a benzodiazepine drug commonly used to treat a wide range of conditions.

16.3 **Arrest of Q for disorderly conduct: July 2009**

16.3.1 On 4 July 2009 a resident of the road in Stoke-on-Trent where Q resided reported to the Police that a man had gone berserk in the street and had smashed up a TV. Upon Police arrival it was identified that Q had tipped the contents of a bin into the road because he believed that the traffic had been travelling too fast and decided to create a road block. Q was arrested for being drunk and disorderly and later cautioned for this offence.

16.4 **Q overdose: July 2009**

16.4.1 On 10 July 2009 Q was taken to the hospital Emergency Department by ambulance having drunk a bottle of wine and taken 15 unknown tablets. He was assessed as having no suicidal intent but wanting to calm down. Q expressed the wish to reduce his alcohol intake and was referred to ADSIS[11]. As a consequence of the ADSIS information retention policy, records for this period are not now available and it is unknown whether Q accessed any service.

16.5 **Assault on P: July 2009**

16.5.1 On 19 July 2009 the Police received a call from the West Midlands Ambulance Service advising that they were attending an address in Stoke-on-Trent, following a report that a man and a woman had been thrown out of a car and that both had head injuries. Despite her injuries the woman informed ambulance service staff that she had not been assaulted but had fallen over. She ran off on arrival of the Police.

16.5.2 Police Officers found P, who was intoxicated, lying on a sofa within the address with a head injury. Due to his demeanour the ambulance service staff would not convey P to hospital and he was taken in a police vehicle. At the hospital, P was examined and found to have a small graze to his head which raised no concerns. It was however noted that P’s head had been shaved and that he had nail varnish over his face and head. P would not provide an account of how this had happened. He was discharged when he was sober.

16.5.3 Police enquires subsequently identified that a car had pulled up in the street and two females had helped P, who was in a drunken state, out of the car and into the address. Both females then left in the car but approximately twenty minutes later one of them had returned and spoken with the ambulance service staff. No further information regarding the background to the incident was able to be obtained and it was recorded as a suspicious incident.

> The Review Panel considered that for a drunk male in this condition there would be an assumption that it was the result of a ‘prank’. Conversely, if it had been a female presenting at the Emergency Department with a shaven head and covered with nail varnish, domestic abuse would in all likelihood have been suspected.
>
> It should however be noted that there is no indication that Q was in any way involved in the incident.

16.6 **P possession of a knife: July 2009**

[11] In 2009 Adsis, a third sector organisation, were offering alcohol and drug support in Stoke-on-Trent and Staffordshire.

16.6.1 On 23 July 2009 a member of the public contacted the Police to report that a male with a knife had tried to get into an address in Stoke-on-Trent. Police Officers attended the address and found P in an intoxicated state in the garden of the property and in possession of a knife. He was arrested for possession of an offensive weapon but subsequently released without charge as the original informant would not provide a statement and it could not otherwise be evidenced that P had the knife in a public place.

16.6.2 Whilst in custody P was referred to ADSIS for support in respect of his alcohol misuse. An invitation to a drop-in session was sent to P but there is no extant record of him accessing any service[12].

16.7 Alleged Assault on Q by a third party: August 2009

16.7.1 In August 2009 Q reported to the Police that a female relative had come to his home and assaulted him, causing facial injuries from which he was bleeding. Q subsequently stated that he had had a violent argument with his relative's father earlier in the evening and this may have been the reason that he was assaulted. Q stated that he did not wish to make any complaint about the assault.

The Police report identifies deficiencies in compliance with procedures for the recording of this assault by Staffordshire Police but identifies that the recording of crimes has subsequently been improved dramatically through centralisation of this function in a Crime Administration Unit (CAIU), with cross checking against incident records, oversight by 'Dedicated Decision Makers' and regular audit by the Force Crime Registrar.

16.7.2 Between February 2009 and April 2010 there were eight other occasions when P had contact with the Police and/or health services as a result of him being found incapable or disorderly through excessive drinking. On two of these he was accompanied by Q who was also drunk. At the time of these contacts P commonly exhibited minor injuries consistent with having fallen. He declined to engage with alcohol misuse services.

16.8 Domestic Incident involving P and Q: May 2010

16.8.1 On the evening of 7 May 2010 a member of the public reported to the Police that he had seen Q assault another man in his home address and that Q had had a knife which he had thrown onto a windowsill. The caller did not know who the other man was or see if he had any injuries but stated that Q had "done this sort of thing before".

16.8.2 The attending Police Officers identified the two men involved in the incident as Q and P who were both extremely drunk. The Police were informed by Q that he had an issue with children gathering outside his house and both P and Q stated that there had been no assault. Neither had any injuries. A broken kitchen knife was found in the lounge by the Officers.

16.8.3 When spoken to by the Police, the original caller stated that he had only seen one of the men fall over the sofa and had not actually seen any assault take place.

16.8.4 This differing information from the caller, in conjunction with Q and P's account that there had been no assault and that neither of them had any injuries caused the attending Officers to

[12] As a consequence of ADSIS' information retention policy records for this period are not now available.

ask for the incident to be reclassified from violence against the person to an incident of antisocial behaviour and this was agreed.

The incident was reviewed by the Police Crime and Incident Validator at the time and it was commented that this was a “third party report, victim refuses to confirm crime and therefore incident to remain as a Crime Related Incident”. This perspective has been reviewed by the same validator and the Force Crime Manager as part of this Review and confirmed to have been appropriate to the information available at the time.

16.9 P and Q contact with Police and health services: May 2010 – January 2013

16.9.1 In May 2010 P was taken to the hospital Emergency Department by ambulance having reported that he fell and sustained an ankle injury 2 days previously. He informed the hospital staff that this had been the result of falling down stairs having tripped. X-rays showed a fracture to his calcaneum (heel bone). P had a number of follow up appointments at the fracture clinic between then and August 2010 when he was discharged.

16.9.2 In December 2010 West Midlands Ambulance Service attended Q’s home address following a 999 call reporting that a man had fallen down the stairs and knocked his head. P, who was noted to be intoxicated, was taken to the hospital Emergency Department by ambulance but left before being triaged.

16.9.3 In November 2010 and March 2011 the Police had contact with Q and P on two further occasions when they were drunk together. On neither of these occasions was there any indication of violence between them.

16.9.4 In April 2012 Q requested a prescription for Olanzapine[13] from his GP. This was declined but Q was again referred to the North Staffordshire Combined Healthcare NHS Trust Access Team with a request for an assessment of his mental health. Identified presenting features included anxiety and alcohol misuse. A telephone assessment was completed with Q but the Access Team were thereafter unable to contact him to arrange a face to face appointment. Q was discharged in May 2012 in accordance with the Trust’s policy on non-engagement, with letters being sent to him and his GP advising of this.

16.9.5 In January 2013 Q contacted the Police via 999 and the call was then cleared. The call taker was able to re-contact Q who said that he had rang because had thought things were getting out of hand but the issues had been sorted out and there was no need for the Police to attend. The call record was closed with no further action.

Had the incident on 7 May 2010 been recorded as involving domestic abuse it is likely that Police officers would have been deployed to Q’s address in response to this call. It is however unknown what the outcome of such a response would have been.

16.10 Admission by Q to assaulting P: March 2013

16.10.1 On the evening of 17 March 2013 Q called the West Midlands Ambulance Service and reported that P had had a fall. On their arrival Q informed the ambulance service staff that P was his partner and that he had assaulted him by “kicking his head in”. P denied this and stated that he had fallen over. P was taken to the hospital Emergency Department.

[13] Olanzapine is an anti-psychotic drug.

16.10.2 The incident and the admission to assaulting P made by Q were not reported to the Police.

16.10.3 At the hospital old injuries to P's face, a wound to his right ear and swelling to his forehead were recorded. P also complained of back and chest pain, stated by him to be the result of falling over repeatedly in previous months, and was found to have bilateral bruising to his lower chest.

16.10.4 West Midlands Ambulance Service confirmed to the Review Panel that Q's admission to assaulting P and their consequent classification of the incident as involving domestic violence was shared with staff of the Emergency Department both electronically (by docking the ambulance service electronic recording equipment) and also verbally in the presence of P. UHNM confirmed that there was no documentation within the ED notes to suggest that staff were aware that P's injuries were as a result of domestic violence. Medical notes indicated that he had reported falling over, which had exacerbated his chronic back pain. The docking of the ambulance service electronic records is not available to ED staff in real time and therefore verbal communication is relied upon. As a consequence no action was taken to report the incident to the Police or to secure support for P from, for example, the Arch staff who work in collaboration with the Emergency department.

16.11 P contact with health services: May 2013

16.11.1 On 15 May 2013 P visited the Stoke-on-Trent Walk-in Health Centre with a head injury, stating that he had fallen onto a television at a friend's house whilst drunk. He was recorded as having lacerations to his head and left ear which were dressed.

The Panel considered whether the incidence of ear injuries (this was the second sustained by P in two months) was indicative of domestic abuse. It was concluded that they were not and could be equally attributed the effects of excessive drinking.

16.12 Q self-referral to Aquarius and North Staffordshire Combined Healthcare NHS Trust: July 2013

16.12.1 On 19 July 2013 Q referred himself to Aquarius, stating that he had not had a drink for the last two days but used to drink 8 cans a day. He said that he had periods when he did not drink but used alcohol as a coping mechanism. He also stated that he could get verbally and physically aggressive when intoxicated, had beaten up his friend and he understood that he had anger issues. A triage appointment was arranged for 23 July 2013 at an outreach venue in a local college. In the interim Q was signposted to local mental health support charities, although he did not follow these up.

16.12.2 No risk assessment was completed by the Aquarius Support Worker receiving the referral and the admission by Q to assaulting his 'friend' was not communicated to any other agency.

16.12.3 Also on 19 July 2013 Q self-referred to the North Staffordshire Combined Healthcare NHS Trust Access Team, requesting support with anxiety and depression. It was decided to offer an appointment for initial assessment of Q and numerous unsuccessful attempts were subsequently made to contact Q to arrange this.

16.12.4 Q did not attend the planned assessment meeting with Aquarius on 23 July 2013 and attempts were made to contact him for this to be re-arranged.

16.13 Q assault on P: August 2013

16.13.1 On the afternoon of 7 August 2013 a second Aquarius Support Worker contacted Q by telephone. During the call Q disclosed that he was beating up his partner and that he had been doing this since the previous night. P then came on the line and stated that Q had hit him the previous night, had continued to hit him through the day and that he had been bleeding.

16.13.2 The Aquarius Support Worker informed her Team Leader of the circumstances and reported the content of the call to the Police.

16.13.3 Police Officers visited the address of Q and P. They were admitted by Q who said straight away, "I've battered him". Q was arrested for assault on P and cautioned, to which he replied "I have battered him with my fists, elbows and knees. He's got a fractured skull. I battered him last night". This comment was recorded by the Police Officers and was signed by Q. Head injuries to P were also photographed by the Police Officers.

16.13.4 P was taken by ambulance to the hospital Emergency Department where a history of P having been assaulted by an "Acquaintance / Friend" was verbally passed to Emergency Department staff. This was also recorded on the ambulance service electronic record which was docked at the hospital.

16.13.5 However, the hospital staff recorded (incorrectly) that P had been found intoxicated in the street by the Police. At the hospital P's injuries were recorded as an infected wound to his ear, noted as probably 48 hours old when P did admit to having been assaulted, as well as old swelling and bruising to the right side of his forehead. P did not disclose to hospital staff that he had been the victim of domestic violence and this was not explored. His wounds were cleaned and he was discharged.

16.13.6 P provided a statement to the Police but declined to make a complaint, stating that he had not been assaulted by Q and explaining his injuries as the result of falls whilst he was drunk.

16.13.7 Q was interviewed in relation to assaulting P. He stated that due to his drunken state he had no recollection of making any disclosures to the Aquarius Worker or the significant statements he had made to the attending Police Officers. Q denied assaulting P. He stated that he had asked P how he had come by his injuries after finding blood in the bathroom and that P had replied "I must have had a fit".

16.13.8 The investigation was referred to the Crown Prosecution Service (CPS) for a charging decision, which was that no charges should be brought against Q. In the review of the evidence, the CPS considered the reliability of the 'admissions' made by Q as an alcoholic who was intoxicated when officers arrived at the address and advised "It is highly unlikely that anything stated by him will be accepted as reliable by a court". Also that there was no evidence to contradict P's statement that the injuries resulted from a fall.

16.13.9 The CPS concluded the review by stating "In the absence of independent evidence to support the allegation of assault there is no realistic prospect of conviction". Q was released from custody with no further action being taken against him.

There was effective evidence gathering by the attending Police Officers and the action taken in respect of arresting and interviewing Q was entirely appropriate.

Notwithstanding this the Police report and the Review Panel concur with the CPS view that prosecution of Q presented no realistic prospect of conviction.

16.13.10 A DIAL[14] risk assessment form in respect of P was not completed by the Police Officers who attended and arrested Q. After a number of unsuccessful attempts P was eventually spoken to regarding this on the morning of 8 August 2013 but would not answer any of the risk assessment questions and a decision was taken not to submit the risk assessment form.

16.13.11 A second officer was subsequently directed to visit P and complete the DIAL form but again P refused to cooperate and the form was not completed. The incident was however flagged for consideration by the MASH.

16.13.12 Consequent to the incident being flagged to the MASH, completion of a DIAL form by the attending officer was requested by a MASH Case Handler. No action was however taken in response to this request, it was not further followed up and a DIAL form was not completed within the MASH from the information already recorded.

16.14 Q involvement with Aquarius, North Staffordshire Combined Healthcare NHS Trust and Stoke-on-Trent City Council: August 2013 – May 2014

16.14.1 On 8 August 2013 the Aquarius Team Leader informed staff that a risk management plan was being drawn up in respect of Q and that until further notice any contact with him was to be referred to a team leader.

16.14.2 Also on 8 August 2013 the Aquarius Support Worker was updated on the outcome of the criminal investigation regarding the incident on 7 August. This was recorded in Q's client record but did not result in reassessment of the risk level, any update on how the case was to be managed or consideration of whether any other action was required as a consequence.

16.14.3 On 12 August 2013 Q contacted Aquarius by telephone and stated that he was very confused and required help because he was violent. The call was referred to the Team Leader, to whom Q recounted a number of concerns that he had about his mental health and recent behaviour. He stated that he was thankful for the actions of Aquarius in calling the Police as he felt this was "just what he needed" however he was not happy that his partner had dropped the charges.

16.14.4 Q explained that he drank an undisclosed amount of strong lager every day and that he was also taking cocaine and M-CAT[15]. He reported that he had "tried to kill" his brother and his family were at the point of disowning him due to his violent behaviour[16]. Q stated that he had not seen his GP as he was scared of doctors. He then explained in depth that he had premonitions, had predicted 9/11 three days before it happened, had also predicted the 7/7 London bombings and Madrid bombings and that he suffered from PTSD as a result of the premonitions.

[14] A Domestic Incident Arrest Log (DIAL) form is used within Staffordshire Police to assess the level of risk within domestic abuse cases. The guidance on DIAL completion is contained within the Staffordshire Police Domestic Abuse Procedure. "It is MANDATORY that a DIAL Risk Assessment is completed for ALL crimed domestic violence and abuse incidents or when any of the (specified) criteria apply and that it is forwarded to the Multi-Agency Safeguarding Hub (MASH) at the earliest opportunity and in any event by the end of the officer's tour of duty. There will be a presumption that DIAL Risk Assessments will be completed face to face with the victim by the initial attending officer; they will be completed on a mobile device and submitted electronically to MASH."

[15] M-CAT (Methylmethcathinone is an illicit synthetic stimulant drug.

[16] There is no record of this held by any agency and it was not referred to by any family member during the subsequent homicide investigation.

16.14.5 Q stated that he felt very low and could be violent. He said he wanted someone to come to his house and care for him. It was explained that this would be difficult in view of his violence and arrangements were made for a telephone assessment with Aquarius two days hence. Q also consented to Aquarius making a referral to the NSCHT Access Team as a follow up to his self-referral.

16.14.6 A risk assessment completed by the Aquarius Team Leader identified high risk levels in respect of domestic abuse, violence or harm to others and to Q's health. The main contributing factor to these risks and potential escalation was identified as alcohol and drug use.

16.14.7 The resultant action plan for Aquarius included telephone triage assessment of Q by an Aquarius Project Worker, referral of Q to the NSCHT Access Team for assessment of his mental health and restriction of staff contact until this assessment had been completed.

The Aquarius report highlights a number of deficiencies in the risk assessment and management plan, including that there was:

- No mention of Anger Management
- No mention of accessing Arch domestic abuse perpetrator provision
- No referral to MARAC
- No consideration of Detox options
- No contact with the Police to seek information on Q's offending history
- No contact with P to discuss the increased risk when one or both parties used alcohol or other substances and engagement of domestic abuse support services
- No referral to CRI[17] regarding drug use.
- No action specifically aimed at reducing either the level of Q's substance misuse or the level of risk

The deficiencies in their service provision identified by Aquarius continued throughout the involvement of that agency with Q and a Care Plan for Q was never implemented.

16.14.8 On 12 August 2013, following initial telephone contact, Aquarius sent a referral to the NSCHT Access Team in respect of Q. No evidence was found within the client record to suggest that the referral included the risk assessment and risk management plan.

The Aquarius report notes that their risk assessment and management plan should have been shared with the Access Team.

16.14.9 On 14 August 2013 an Aquarius Project Worker completed a telephone triage assessment of Q who stated that he had been drinking since the age of 14 and had always struggled with both alcohol and drugs. He described drinking between six /twelve cans of 9% lager and smoking £10 pounds worth of cannabis daily.

16.14.10 Q also said he was previously prescribed anti-psychotic medication by his GP but he had a fear of leaving his home unless he is either under the influence of street drugs or alcohol so he had had many failed GP appointment's and now only took medication for his indigestion.

16.14.11 Q explained how both alcohol and street drugs changed his personality and said he could become very aggressive, confrontational and challenging. He stated that he desperately wanted to engage with Aquarius support but his partner P was also a dependent drinker and he felt that until his partner also engaged with alcohol support a detox would be futile.

[17] Crime Reduction Initiatives (CRI) is a voluntary sector organisation specialising in drug and criminal justice intervention projects in England & Wales.

16.14.12 The Project Worker informed Q that to minimise risk Aquarius would have to have his support sessions in a health / professional setting. From then until 19 September 2013 the main preoccupation of the Aquarius Project Worker was identifying a suitable venue to meet with Q and there is no evidence of any other intervention taking place.

On interview for this Review the Aquarius Worker stated that finding a venue at which to meet Q where risks to staff and others could be minimised became his main focus and distracted him from the presenting issues and the actual service provided. He acknowledged that his practice in the case should have been much better.

The Aquarius report also identifies that there was no evidence of effective supervision of the Worker by his Team Leader taking place throughout their involvement with Q. This was attributed in part to a difficult relationship between the two professionals.

16.14.13 On 15 August 2013 the Aquarius Worker contacted Q's GP surgery. An outline of the recent events was shared with a locum GP. There was however no discussion of engaging the GP in the risk management or support of Q and the main purpose of the contact was to secure a venue at the surgery for future Aquarius contact with Q.

16.14.14 On 19 August 2013 the Aquarius Project Worker advised Q that he was attempting to arrange to meet him at the GP surgery and would re-contact him when this was done. During the call he also secured Q's agreement for a referral to be made to CRI for drug misuse support, although there is no evidence that this referral was made.

16.14.15 On 27 August 2013 the Stoke-on-Trent City Council Community Support Officer visited Q at his home and was advised that P, who arrived during the visit, was his partner and was living with him at the address. Q stated that this this arrangement had commenced on 7 July 2013 although it is clear that it was significantly more longstanding.

It appears that the decision to formally notify the Council of P's residence with Q was prompted by a desire to negate liability for the 'Spare Bedroom Subsidy'[18].

16.14.16 From this date onwards the Community Support Officer, working in liaison with the Housing Officer, provided on-going support to Q in respect of benefits, rent and Council Tax arrears and the wish of Q and P to move to a smaller property. This involved a number of contacts and visits each month even when engagement from Q was not forthcoming. Unaware of Aquarius' involvement, Q was offered further support in accessing services to address his alcohol misuse but declined this and said he didn't feel he needed any help. It was noted by the housing staff that direct engagement with them by P was limited and that he was usually seen only in the background when they were engaging with Q.

16.15 NSCHT mental health screening of Q: September 2013

16.15.1 On 16 September 2013 Initial telephone screening of Q was carried out by the NSCHT Access Team following numerous earlier unsuccessful attempts to contact him.

16.15.2 Q provided information regarding his personal circumstances. He stated (inaccurately) that he lived alone and was seeking alternative housing due to his current accommodation being

[18] Following introduction of the Welfare Reform Act (2012) social housing tenants in receipt of housing benefit would have to pay a contribution to their rent if it was deemed that they had a spare or surplus bedroom. This change impacted around 3,000 council tenants across the city.

too big for his needs and that he hated living in the area despite living there for 21 years. Q disclosed that he had a violent past and had difficulties managing his anger when intoxicated. He also disclosed a history of domestic violence in a previous relationship.

16.15.3 During the interview Q stated that he was currently single and talked about a female ex-partner who had died some seven years previously. He did not disclose that he was in a relationship with P.

16.15.4 The assessment identified that there were no mental health concerns that required the intervention of secondary mental health services and his primary needs related to alcohol misuse and social issues (housing and benefits) which were being addressed by the relevant services.

> The documentation used by the Access Team during 2013 only collected information on a service user's marital status and not detailed information regarding family composition. During 2014 this documentation was revised and detailed information regarding family members and significant others is now collected. However, the North Staffordshire Combined Healthcare NHS Trust report concludes from the records and interviews with staff that the information disclosed would not have been any more comprehensive or accurate if the new documentation had been used in 2013.

16.15.5 As Q only disclosed violence in relation to a previous relationship, and claimed that he was not currently in a relationship or co-habiting, the risk of harm to others was considered low.

> A significant factor in reaching this conclusion was the absence of a comprehensive referral, with their risk assessment, from Aquarius. The assessed level of risk was however immaterial to whether Q required secondary mental health services.

16.15.6 North Staffordshire Combined Healthcare NHS Trust recorded that on 17 September 2013 the Aquarius Worker was informed of the outcome of their assessment and agreed that there was no role for the Access Team in the support of Q which would continue to be provided by Aquarius. Following the conversation Q was discharged by NSCHT.

16.15.7 The Aquarius Project Worker however recorded being advised that NSCHT could not support Q with his mental health issues whilst he was drinking but that once Q he had completed an alcohol detox they could support him.

> NSCHT have confirmed to the Review that even if Q had completed a detox programme and was alcohol free he would not have received a service as he did not have an identified and treatable mental health condition.
>
> The actual content of the conversation cannot be determined. The discrepancy between the two professionals' perception of what was discussed and agreed is attributed by the Review Panel to ineffective communication, exacerbated by the absence of written confirmation being provided by NSCHT.

16.15.8 On 19 September 2013 Q did not attend an arranged appointment with Aquarius. The Aquarius Project Worker contacted Q who advised that he had no money. An appointment was then made to see Q on 24 September 2013 at a public library nearer to his home.

> Aquarius records do not indicate and their Project Worker has not shed any light on the rationale for agreeing to see Q in an unmanaged community setting having devoted so much time and energy attempting to arrange it at a venue where the risk that he was assessed to pose could be managed.

16.15.9 On 24 September 2013 Q again did not attend his appointment with Aquarius. Q was contacted by telephone and said that he had no money to attend his appointments. It was suggested to Q that he should think about whether he still wanted to engage with Aquarius support and he was asked to contact the Project Worker with his next availability for an appointment. Q agreed to do this but did not re-contact the Worker.

16.15.10 On 11 October 2013 the Housing Officer and Community Support Officer visited Q and P and discussed their housing and benefits situation. They were advised that unless their rent arrears were cleared a move to another property would not take place. Q stated that he would pay off the arrears. Q and P claimed that they had no food in the house and arrangements were made for them to receive a food bank voucher

16.15.11 On 17 January 2014 P attended the hospital Emergency Department stating that he had slipped on ice two days previously and injured his ankle. X-rays identified the healed fracture from May 2010 but no acute fracture was visible. He was referred to the fracture clinic but did not attend two appointments for the ankle to be scanned. He was eventually discharged from the clinic in April 2014 when contact was established and it was noted that he was walking freely with no problems.

16.15.12 Also on 17 January 2014, Aquarius sent a letter to Q advising him that his case would be closed unless he made contact within the next 7 days. Having received no contact from Q the case was closed on 24 January 2014.

The Aquarius report observes that expected best practise required the Project Worker to make contact with Q to discuss closure of the case before doing so and that this was particularly significant when Q's assessed level of risk remained so high. It seems unlikely however that with Aquarius having not provided any service to address Q's substance misuse over the preceding five months, direct contact would have secured any engagement at this point.

16.15.13 On 3 February 2014 the Community Support Officer visited Q and P. They were advised that due to the history of non-payment of rent the Council would not re-house them but only consider them for the (Deposit) bond scheme in private rented accommodation. They were given a list of accredited landlords to contact. .

16.15.14 On 11 March 2014 the Housing Community Support Team took a call from Q who sounded under the influence of alcohol. He was quite aggressive and stated that he "didn't know what (the Community Support Officer) had ever done for him as he felt he was having to do everything for himself." The call was discussed with a Manager and it was agreed to continue to support Q but to confront his behaviour. This support continued up to and including the day before P's death.

16.15.15 In May 2014 the Community Support Officer visited Q and P at home, discussed the bond scheme and advised that they started to ring round different letting agencies. Q rang a few for them during the visit. He was advised to keep trying and agreed to do this.

16.15.16 There was no indication during this visit of any development or trigger that may have preceded the murder of P on the following day.

There is no evidence within any of the City Council Housing records which would indicate that domestic abuse was ever apparent within the household. The housing department could have been made aware of domestic abuse Q by a number of agencies, and should have been informed by the Police and Aquarius, but were not. This is attributable to a less than

effective approach to partnership working between the agencies. The City Council report highlights that this situation has been addressed through the current Cooperative Working arrangements (see 14.5.7).

It might also have been expected that neighbours or acquaintances may have informed the housing staff, with whom many residents would have routine contact, of violence within the relationship but they did not. This was discussed by the Panel and the conclusion reached that the most significant barrier to this was that housing staff were viewed as "authority".

16.16 **Murder of P**

16.16.1 The day after the housing department staff visit in May 2014 the West Midlands Ambulance Service received a 999 call from Q stating that his boyfriend had bled in the house and urinated on him whilst drunk and that he had thrown him out of the house. P was stated to be unconscious. On arrival the ambulance service staff found that P was seriously injured and requested that the Police attend.

16.16.2 As the Police arrived P went into cardiac arrest. Attempts were made to resuscitate P in the ambulance whilst still at the scene but he died a short time later.

16.16.3 Q was initially arrested for assaulting P and later further arrested for the murder of P.

16.16.4 Q was interviewed on two separate occasions. On his first interview, Q denied that he had caused the injuries to P and maintained that he had woken up to find P lying on the kitchen floor with a head injury. Q stated that P was able to get to his feet but fell over, banging his head on the kitchen floor and that blood was pouring out of the wound. He then moved P outside the back door before coming back inside to phone for the ambulance.

16.16.5 On the second interview, Q was asked questions in relation to discrepancies in his account compared to other evidence that had been gathered and questions in relation to the injuries that P had sustained. Q replied "no comment" to all of these questions.

16.16.6 In relation to the injuries suffered by P, the pathologist report identified 99 separate injuries across his body including 15 broken ribs, a punctured lung, a tear to his liver that resulted in massive blood loss and impacts to his head with a linear edged/profiled structure indicative of being struck with a table leg.

16.16.7 Q was charged with the murder of P. Q subsequently pleaded guilty to the murder of P and was sentenced to life imprisonment.

FINDINGS AND CONCLUSIONS

17 P as a Victim of Domestic Violence and Abuse

17.1 It is clear that throughout the period under review P was being abused by Q. Family members had seen injuries to P and they believed or even knew that Q had caused those injuries. P would not however admit to this, maintained that they were accidental and the abuse was never reported by them to any agency at the time.

17.2 Since the death of P evidence has been gathered which demonstrates that as well as violence there was a controlling aspect to the relationship between Q and P with references to P being bullied, including into borrowing money from his family to buy alcohol. A combination of such bullying, P's chronic abuse of alcohol and his dependency on Q to provide him with a home and a relationship left him in a very vulnerable position from which escape without considerable support was considered by the Review Panel to be unlikely.

17.3 In Stoke-on-Trent a comprehensive range of services for victims of domestic abuse are available (see section 13). P did not however access these services and all of the opportunities for professionals to refer P into the service provision were missed. It is far from certain that P would have engaged with any service to which he was referred, or whether this would have changed the eventual outcome of his continued relationship with Q, but a proactive and supportive approach to him from a professional with the relevant skills and experience would have increased the chances of this.

17.4 The Review Panel identified that P was almost invisible as an individual to services other than the Police and the hospital Emergency Department. Even when City Council housing department staff latterly had considerable engagement with him and Q in relation to their benefits, payment arrears and desire to obtain a joint tenancy, P was largely in the background rather than an active participant.

17.5 At no time did P disclose to any professional that he had been assaulted or otherwise abused by Q. Even (see below) when Q admitted to assaulting P this was, with one exception in August 2013 and then retracted, denied by him with an insistence that injuries sustained were the result of falls and trips whilst drunk. The Review Panel noted that throughout the period under review the injuries to P seen by professionals were consistent with the consequences of alcohol abuse. Furthermore, the Review Panel noted that P more readily fitted the appearance and presentation of an alcoholic rather than that of a domestic abuse victim.

17.6 **Missed opportunities**

17.7 There was however one incident from which domestic abuse in the relationship between P and Q might have been recognised and a further three occasions when admissions by Q to assaulting P should have led to P being identified and responded to as a victim of domestic abuse. The reasons that these opportunities were missed represent learning from this Review.

17.8 <u>May 2010</u>

17.8.1 When the Police responded to an incident involving Q and P in May 2010 (see 16.8) the couple were not identified as being in an intimate relationship. This was not mentioned in the initial report and the informant may well not have known this. Nevertheless, the nature of the relationship behind Q and P's cohabitation could have been explored, with identification of an

intimate relationship leading to the recording of a domestic abuse incident. With the nature of the incident it is unlikely that this would have led to P or Q being referred to domestic abuse services although these may well have been signposted. More significantly the recording of a domestic abuse incident itself would have acted as a flag to inform the response provided to later incidents.

17.8.2 The Review Panel observed that if the incident had involved a man and a woman it is far more likely that an intimate relationship would have been assumed and that the perspective taken in this case reflected cultural stereotyping.

17.8.3 The Police report highlights that the definition of domestic abuse within their policy framework, reflecting Government guidance, 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…."

is less encompassing than that applicable to Domestic Homicide Reviews which additionally includes;

> "…a member of the same household…".

17.8.4 Further, that if the definition of "domestic abuse" reflected that used for Domestic Homicide Reviews the incident between P and Q would have been captured as a "domestic incident" even if the true nature of the relationship had not been established and that accordingly safeguarding measures may have been initiated.

17.8.5 The Panel concluded that a widened definition of domestic abuse should not have been necessary to trigger a domestic abuse response but considered whether this would provide an additional safeguard in cases where cultural assumptions regarding domestic abuse may lead to under recognition of victims[19].

17.8.6 On balance it was concluded that to include within the domestic abuse definition all of the many relationship types in which two people shared the same household would undermine the effective targeting and prioritisation of domestic abuse services.

17.9 March 2013

17.9.1 In March 2013 the West Midlands Ambulance Service were informed by Q that he had assaulted P, causing the injuries to which they were responding.

17.9.2 This should have been reported to the Police. However the initial call to the ambulance service had been recorded as a fall, and although the incident was subsequently re-classified as involving domestic abuse West Midlands Ambulance Service at that time took no direct action to report domestic abuse cases, on the assumption that they would be picked up by other agencies.

17.9.3 The West Midlands Ambulance Service provided assurance to the Review Panel that procedures had since changed, and that from April 2014 these have ensured that safeguarding referrals to the Police are made through the dedicated Ambulance Service Safeguarding Hub in cases where domestic abuse is suspected. Where there are significant concerns about a victim's safety this would be irrespective of whether consent was granted.

17.9.4 That staff of the hospital Emergency Department did not respond to P as a victim of domestic abuse is attributable to communication by the ambulance service staff of Q's admission to assaulting P and their classification of the incident as involving domestic abuse not being

[19] Including familial relationships, within which there is evidence of an increasing incidence of child on parent abuse.

recognised by the hospital staff or included in P's hospital notes. Consequently there was nothing to contradict P's account of his injuries being accidental.

17.9.5 The docking of electronic information held by the Ambulance Service does not make it available to Emergency Department staff in real time, therefore it is essential that the verbal hand-over is both given and received accurately and documented accordingly. University Hospitals of North Midlands NHS Trust has not been able to identify why the information passed verbally to Emergency Department staff in respect of P was not recorded or acted upon. No recommendation on this issue is made by the Trust in their report and accordingly it is recommended by the Review Panel:

That University Hospitals of North Midlands NHS Trust review their arrangements for receipt of admission handover information and ensure that all relevant information is recorded in a way that is readily accessible to clinical staff.

17.10 <u>July 2013</u>

17.10.1 When Q self-referred to Aquarius in July 2013 and disclosed that he had "beaten up" his friend no action was taken to explore this with P, to ensure that he was safe or to communicate the information to any other agency.

17.10.2 Aquarius operating procedures are clear that this disclosure should have led to completion of a risk assessment and that it should have been reported to the Police. That this did not take place is attributed by Aquarius to the Support Worker involved being new in post and relatively inexperienced and further that the Team Leaders were not experienced enough to provide proper supervision of the case. The overall quality of Aquarius staff practice in this case is discussed at section 19 below.

17.11 <u>August 2013</u>

17.11.1 In August 2013 Q again disclosed to Aquarius that he had assaulted P and exceptionally this was confirmed by P, albeit when P spoke with all other professionals he reverted to denial of being assaulted and maintained that his injuries were accidental. On this occasion the Aquarius Support Worker did appropriately report the matter to the Police but a number of factors conspired to undermine this opportunity to recognise and respond to P as a victim of domestic abuse.

17.11.2 First, the handover of information from West Midlands Ambulance Service that P was a victim of assault, as in March 2013, did not lead to recognition that his injuries were the result of domestic violence. The engagement of the hospital's arrangements for responding to this was not therefore triggered. A recommendation in respect of ambulance service patient handover to the hospital is made at 17.9.5 above.

17.11.3 Second, although the crime investigation conducted by Staffordshire Police was of a good standard, a DIAL[20] risk assessment form in respect of P was not completed by the officers initially attending, those subsequently directed to do so, or the Case Handler within the MASH to which the incident was flagged.

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[20] A Domestic Incident Arrest Log (DIAL) form is used within Staffordshire Police to assess the level of risk within domestic abuse cases. The guidance on DIAL completion is contained within the Staffordshire Police Domestic Abuse Procedure. "It is MANDATORY that a DIAL Risk Assessment is completed for ALL crimed domestic violence and abuse incidents or when any of the above criteria apply and that it is forwarded to the Multi-Agency Safeguarding Hub (MASH) at the earliest opportunity and in any event by the end of the officer's tour of duty. There will be a presumption that DIAL Risk Assessments will be completed face to face with the victim by the initial attending officer; they will be completed on a mobile device and submitted electronically to MASH."

17.11.4 Completion of a DIAL risk assessment is mandatory where a domestic violence related crime is recorded and the injuries to P and the initial admission of assault by Q provided enough information with which to at least partially complete the DIAL form, irrespective of P's willingness to cooperate. The Police report also highlighted that a DIAL form could have been initiated within the MASH in the absence of information being provided from the attending Officers.

17.11.5 If a DIAL form had been completed it would have triggered lateral checks with other agencies through the MASH. The Staffordshire Police Domestic Abuse and Case Conferencing Manager has reviewed the information available at the time and concluded that the injuries to P's head and face alone would have placed the relationship in the High Risk category and that with all of the other factors included the case would have been referred into the Multi-Agency Risk Assessment Conference (MARAC) process. This would have led to:

- Flags being placed IT systems against the home address of Q and P
- Lateral checks with other agencies which would have revealed previous assaults on P ,
- Referral of P to the male Independent Domestic Violence Advisor, who would have made contact with P prior to the MARAC and both offered support and ensured that P's voice was represented at the conference
- Initiation by the Police of the 7 Step[21] Domestic Abuse Plan
- A request for Aquarius to engage with P as well as Q.

17.11.6 The failure to comply with requirements in respect of DIAL form completion has been addressed by Staffordshire Police with the staff concerned. It is however clear that compliance with the requirement to complete the risk assessment is a more systemic issue.

17.11.7 Data was obtained on completion of DIAL assessments across the Staffordshire Police area, and this showed a fairly consistent compliance rate of around 60-65% from 2013 up to early 2015.

17.11.8 Both Officers who spoke with P were interviewed as part of this Review. Their responses were in line with a finding of a 2013 HMIC[22] inspection of Staffordshire Police arrangements for responding to Domestic Abuse that;

> "It was evident the officers were not aware of the information being added to the databases by the MASH team. Similarly they had not received additional partnership information to assist them in future dealings. Officers stated that the completion of the form has minimum bearing on the action they take with the victim. Therefore, this is primarily seen as a process rather than a useful indicator of risk."

17.11.9 The HMIC inspection identified that "Daily management activity takes place to identify the reasons for the poor compliance and to instruct officers to retrospectively complete DIAL forms." There is however no indication that this has made a significant impact on practice since 2013. The Police report maintains that appropriate action is currently being undertaken to improve this performance but makes a further appropriate recommendation in that regard.

17.11.10 Taking into account that implementation of that recommendation and its outcome would be monitored by the Stoke-on-Trent Responsible Authorities Group the Review Panel concluded that a further recommendation on this was not required.

[21] The 7 Step Plan outlines the means by which Staffordshire Police respond to victims of domestic abuse.
[22] HM Inspectorate of Constabulary.

17.12 **Partnership Working**

17.13 More generally the Review identified that effective information sharing between those agencies who were involved with P and Q was in many respects lacking during the period under review. For example there was no engagement of any agency with the City Council housing department staff and even where agencies such as Aquarius and NSCHT were communicating this did not lead to a shared understanding of or a joint approach to the situation. Consequently, no agency was fully aware of the situation and responses tended to focus on isolated incidents and individual aspects of the relationship between P and Q. This significantly contributed to P not being recognised as a victim of domestic abuse.

17.14 In this context the Review Panel viewed the development in 2014 of more collaborative partnership working arrangements between agencies in Stoke-on-Trent as a positive step forwards.

17.15 **Impact of Sexuality**

17.16 The Review Panel specifically considered how the sexuality of Q and P had affected the way in which they were perceived and the likelihood of P seeking support.

17.17 There was no evidence of intolerance within the community to their sexuality, which they neither hid nor advertised. On the other hand, the fact that they were a gay couple – and not two alcohol misusing men who just happened to live together – was consistently not recognised. Consequently, domestic abuse was also overlooked.

17.18 The Panel considered that, if it had been a heterosexual couple, particularly one where the woman was the victim of domestic abuse, this was more likely to have been recognised and responded to.

17.19 In attempt to gain a greater understanding of the issues that couples in same sex relationships face with regard to domestic abuse, the Police report author spoke with two people who were in separate, same sex relationships.

17.20 Both of these people found themselves to be in similar situations, with some but not all of their colleagues and family members aware that they were gay, not being openly gay in public and were not part of the gay scene. This shows obvious comparisons to the P and Q relationship.

17.21 Both of the individuals expressed that they would certainly not contact the Police themselves to report an incident of domestic abuse. One went further to state that if they had had a domestic abuse incident with their partner and the Police had attended following a third party report, they would not reveal to the Police that it was a domestic related incident for fear of being 'outed' in the community.

17.22 It is widely known that incidents of domestic abuse are greatly unreported for a wide variety of reasons and the above is just one example why this may be a greater issue in same sex relationships.

17.23 The 2014 'Working with Male Victims of Domestic Abuse in Staffordshire and Stoke-on-Trent: Best Practice Guidelines' go some way to addressing issues surrounding male victims of Domestic Abuse but there also has to be a greater understanding of the potentially more complex issues that manifest themselves in abusive same sex relationships, with action taken to encourage reporting by and identification of victims in these relationships.

17.24 The Police report makes an appropriate recommendation to improve the response to domestic abuse within their workforce, supplementing recommendations to build upon current arrangement for male victims of domestic abuse.

17.25 This positive approach does however need to be mirrored across all partner agencies. It is therefore recommended:

That the Stoke-on-Trent Domestic Abuse Partnership consider what further action may be required to address sexuality based social and psychological barriers to victims accessing domestic abuse services.

18 Alcohol Misuse by P

18.1 Throughout the period under review P was a chronic abuser of alcohol and this was recognised by all agencies and professionals with who he had contact. There is abundant evidence of referral to specialist services, including on two occasions in-patient detoxification programmes, being offered but refused. On the occasions when P was referred to specialist alcohol services by his GP and the Police he did not attend the appointments offered or otherwise engage with the services. All indications are that P did not at any point wish to stop drinking alcohol and without that desire any attempt to address P's alcoholism was not going to be successful.

18.2 The Review Panel considered whether P should have been considered a vulnerable adult within the definition of the Staffordshire and Stoke-on-Trent Adult Protection procedures and concluded that he would have not met these criteria at any point.

18.3 The Panel concluded that signposting of Q and P to alcohol misuse services by the attending Police Officers, particularly in the early part of the period under review, would have been appropriate. In this respect the Police report identifies that while the response to alcohol misuse within Police custody arrangements is robust and effective, there is less evidence that signposting or referral is effective when incidents are dealt with away from Police stations. In this respect the Police report observes that Officers are aware of the alcohol support services and referral process but the success of this is largely reliant on the person concerned wishing to engage with such services.

19 Response to Q as a Perpetrator of Domestic Abuse and Substance Misuser

19.1 The disclosures by Q of having assaulted P to Aquarius in July 2013 and then to Aquarius and the Police in August 2013 both suggested a willingness, at least on the face of it, to access services in relation to his abuse of P, but also in relation to alcohol misuse as an underlying factor.

19.2 With regard to the former a Respect accredited domestic abuse perpetrator programme is available in Stoke-on-Trent but the accreditation maintains that heterosexual perpetrators and those in same sex relationships should not attend the same programme. The number of gay men presenting as perpetrators of domestic abuse is currently insufficient to make holding a programme for them in the Stoke-on-Trent area feasible.

19.3 Services to address Q's substance misuse were however available and Q referred himself to Aquarius to access these. A Care Plan to address Q's substance misuse and the risks associated with it was not however developed and implemented. A preoccupation with risks that Q might pose to Aquarius staff, along with poor individual practice and inadequate management oversight led to Q having no face to face contact with the allocated Project

Worker and effectively no service being provided over the next five months, at the end of which Q was discharged.

19.4 Aquarius had in place a full suite of policies and procedures for the management of risk and domestic violence and these were available to all staff, along with the tools and protocols to support them. Aquarius also provided specialist safeguarding and supervision for all staff within their Stoke-on-Trent service. The Aquarius report identified however that in this case these policies and procedures were not followed and the practice was not of the expected standard.

19.5 Aquarius informed the Review Panel that management action was taken in respect of the professional practice in this case. All three of the key staff involved have since left the organisation.

19.6 More widely the Aquarius report identifies that the lessons learnt from their examination of the case have already been shared at a strategic and local level and used improve practice across the organisation. Examples cited were a review of supervision processes, implementing a new electronic case management system and changing culture within the service to promote information sharing and inter-agency challenge.

19.7 The report does not however demonstrate the impact of these or make recommendations for further improvements in their service. It therefore seems appropriate and is recommended:

That Aquarius report to their commissioning organisation and the Stoke-on-Trent Responsible Authorities Group on the measures taken to ensure that their service operates effectively and safely and the impact that these have had on their service provision.

20 Mental health Issues

20.1 **P**

20.2 In 1998-9 P was provisionally diagnosed as having a dissocial personality disorder. There is however no further reference to this, or to any other indication that P might have a mental illness, in his primary care records or the records of his contact with any other agency.

20.3 **Q**

20.4 The Review did not have access to Q's GP records and therefore no direct information on whether Q was receiving primary care treatment for a mental health condition as he claimed when speaking with Aquarius in August 2013. However, referrals from the GP for assessment of Q's mental health in June 2009 and April 2012 suggest that this was not the case during the period under review. In respect of both GP referrals Q did not attend the appointments offered or otherwise engage with NSCHT.

20.5 When the NSCHT Access Team had a third period of contact with Q in July to September 2013, consequent to both a self-referral and referral from Aquarius, he was more prepared to engage with that service. The Access Team screening assessment however identified that Q did not have a mental illness, his difficulties being attributed to substance misuse and social issues. The consequent decision to discharge Q was accordingly appropriate.

20.6 The communication of this decision and the rationale for it was not however clearly understood by Aquarius. The basis for this ineffective communication has not been established but the potential for it could have been reduced if the discharge summary

forwarded to Q’s GP had been copied to Aquarius. NSCHT have confirmed to the Review Panel that the Access Team now routinely forwards a copy of their discharge summary to the professional making a referral as well as the referee’s GP.

RECOMMENDATIONS

20.7 The Review Panel made the following recommendations:

20.8 **That University Hospitals of North Midlands NHS Trust review their arrangements for receipt of admission handover information and ensure that all relevant information is recorded in a way that is readily accessible to clinical staff.**

20.9 **That the Stoke-on-Trent Domestic Abuse Partnership consider what further action may be required to address sexuality based social and psychological barriers to victims accessing domestic abuse services.**

20.10 **That Aquarius report to their commissioning organisation on the measures taken to ensure that their service operates effectively and safely and the impact that these have had on their service provision and that assurance on this provided to the Stoke-on-Trent Responsible Authorities Group [23].**

20.11 Recommendations for action to improve their services were also made by agencies which contributed to this Review. These recommendations are provided at Appendix B.

20.12 Implementation of Action Plans arising from recommendations of the Review Panel and the contributing agencies will be monitored under arrangements agreed by the Stoke-on-Trent Responsible Authorities Group.

[23] In October 2015 Aquarius was decommissioned as the specialist alcohol misuse service for Stoke-on-Trent. Aquarius will however report on the issues recommended in respect of services provided across their organisation which continues to operate elsewhere. The specialist alcohol misuse service for Stoke-on-Trent was recommissioned from Lifeline. That organisation has agreed to report on the effectiveness and safety of their service to their commissioners, who will provide assurance on this to the Stoke-on-Trent Responsible Authorities Group. Responses by both organisations to this recommendation have been included in the Action Plan arising from this Review.

Appendix A

DOMESTIC HOMICIDE REVIEW TERMS OF REFERENCE

1 Introduction

1.1 The Terms of Reference for this Domestic Homicide Review (DHR) have been drafted in accordance with the Staffordshire and Stoke Multi-agency Guidance for the Conduct of Domestic Homicide Reviews, hereafter referred to as “the Guidance”.

1.2 The relevant Community Safety Partnership (CSP) must conduct a DHR when a death meets the following criterion under the Domestic Violence, Crime and Victims Act (2004) section 9, which states that a domestic homicide review is:
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 person to whom he was related or with whom he was or had been in an intimate personal relationship, or
- a member of the same household as himself,

held with a view to identifying the lessons to be learnt from the death.

1.3 An ‘intimate personal relationship’ includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

1.4 A member of the same household is defined in section 5(4) of the Domestic Violence, Crime and Victims Act [2004] as:
- a person is to be regarded as a “member” of a particular household, even if he does not live in that household, if he visits it so often and for such periods of time that it is reasonable to regard him as a member of it;
- where a victim (V) lived in different households at different times, “the same household as V” refers to the household in which V was living at the time of the act that caused V’s death.

1.5 The purpose of undertaking a 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 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 policies and procedures as appropriate; and
- **Prevent** domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

2 Background:

2.1 The victim and alleged perpetrator were in an intimate relationship for around 5 years.

2.2 West Midlands Ambulance Service and Staffordshire Police went to the address shared by the victim and perpetrator in May 2014 consequent to a call from the perpetrator to the effect that a male had fallen and was unconscious. The victim went into cardiac arrest as the Police arrived and attempts to resuscitate him were unsuccessful. He was confirmed dead shortly after his arrival at hospital.

2.3 The perpetrator was arrested and subsequently charged with murder of the victim.

3 Grounds for Commissioning a DHR:

3.1 A DHR Scoping Panel met on 24 June 2014 to consider the circumstances. The Panel agreed that the following criteria for commissioning a Domestic Homicide Review had been met:

CRITERIA:	
There is a death of a person aged 16 or over which has, or appears to have, resulted from violence, abuse or neglect.	**X**
The alleged perpetrator was related to the victim or was, or had been, in an intimate personal relationship with the victim.	**X**
The alleged perpetrator is a member of the same household as the victim	**X**

3.2 The recommendation from a multi-agency Scoping Panel to commission this Review was endorsed by the Chair of the Stoke-on-Trent Responsible Authorities Group on 8 July 2014.

4 Scope of the DHR

4.1 The Review should consider the period that commences from 1 January 2009 up to and including the date of the victim's death. The focus of the DHR should be maintained on the following subjects:

Name	P	Q
Relationship	Victim	Perpetrator
Age	48	45
Date of Death	May 2014	N/A
Ethnicity	White British	White British

4.2 A review of agency files should be completed (both paper and electronic records); and a detailed chronology of events that fall within the scope of the Domestic Homicide Review should be produced.

4.3 An Overview Report will be prepared in accordance with the Guidance.

5 **Individual Management Reviews (IMR)**

5.1 Key issues to be addressed within this Domestic Homicide Review are outlined below as agreed by the Scoping Panel. <u>These issues should be considered in the context of the general areas for consideration listed at Appendix 10 of the Guidance.</u>

- Domestic abuse against the victim, knowledge of and response to this by agencies and why no service for victims of domestic abuse was sought or provided; with particular consideration of;
  - a. the availability and accessibility of relevant services, and
  - b. the impact of the victim's and alleged perpetrator's lifestyle, their extended families and the community within which they lived.
- Domestic abuse by the alleged perpetrator, knowledge of and response to this by agencies and why no service for perpetrators of domestic abuse was provided; including particular consideration of;
  - a. the availability and accessibility of relevant services, and
  - b. the impact of the alleged perpetrator's lifestyle, his extended family and the community within which he lived.
- Alcohol misuse by the victim and perpetrator, and the effectiveness of related services
- Mental health of the victim and perpetrator, and the effectiveness of related services

5.2 Individual Management Reviews are required from the following agencies:

- Staffordshire Police
- University Hospital of North Staffordshire NHS Trust
- North Staffordshire Combined Healthcare NHS Trust
- NHS England in respect of primary care services
- Stoke-on-Trent City Council Housing Services
- Aquarius

5.3 IMR Authors should have no line management responsibility for either the service or the staff who had immediate contact with either the subjects of the DHR or their family members. IMRs should confirm the independence of the author, along with their experience and qualifications.

5.4 Where an agency has had involvement with the victim and perpetrator and/or other subject of this Review, a single Individual Management Report should be produced.

5.5 Background information and a summary of any significant and relevant events outside of the period considered by the review should be included in the IMR.

5.6 In the event an agency identifies another organisation that had involvement with either the victim or perpetrator, during the scope of the Review; this should be notified immediately to Graeme Drayton, Stoke-on-Trent City Council, to facilitate the prompt commissioning of an IMR / Summary Report.

5.7 Third Party information: Information held in relation to members of the victim's immediate family, should be disclosed where this is in the public interest, and record keepers should ensure that any information disclosed is both necessary and proportionate. All disclosures of information about third parties need to be considered on a case by case basis, and the reasoning for either disclosure or non-disclosure should be fully documented. This applies to all records of NHS-commissioned care, whether provided under the NHS or in the independent or voluntary sector.

5.8 Staff Interviews: All staff who have had direct involvement with the subjects within the scope of this Review, should be interviewed for the purposes of the DHR. Interviews should not

take place with any professional who has been interviewed by the Police in connection with this case until the agency Commissioning Manager has received written consent from the Police Senior Investigating Officer. This is to prevent compromise of evidence for any criminal proceedings. Participating agencies are asked to provide the names of staff who should be interviewed to Graeme Drayton, Stoke-on-Trent City Council, who will facilitate this process. Interviews with staff should be conducted in accordance with the Guidance.

5.9 Where staff are the subject of other parallel investigations (including disciplinary enquiries) consideration should be given as to how interviews with staff should be managed. This will be agreed on a case by case basis with the Independent Review Panel Chair, supported by Graeme Drayton, Stoke-on-Trent City Council.

5.10 Individual Management Review reports should be quality assured and authorised by the agency commissioning manager.

6 Summary Reports

6.1 Summary Reports are required from the following agencies:

- West Midlands Ambulance Service NHS Foundation Trust

6.2 The purpose of the Summary Report is to provide the Overview Report Author with relevant information which places each subject and the events leading to this review into context.

6.3 Summary Reports should be quality assured and authorised by the agency commissioning manager.

6.4 In the event an agency identifies another organisation that had involvement with either the victim or perpetrator, during the scope of the Review; this should be notified immediately to Graeme Drayton, Stoke-on-Trent City Council, to facilitate the prompt commissioning of an IMR / Summary Report.

7 Parallel Investigations:

7.1 Where it is identified during the course of the Review that policies and procedures have not been complied with agencies should consider whether they should initiate internal disciplinary processes. Should they do so this should be included in the agency’s Individual Management Review.

7.2 The IMR report need only identify that consideration has been given to disciplinary issues and if identified have been acted upon accordingly. IMR reports should not include details which would breach the confidentiality of staff.

7.3 The Police Senior Investigating Officer (SIO) should attend all Review Panel meetings during the course of the Review.

7.4 The SIO will act in the capacity of a professional advisor to the Panel, and ensure effective liaison is maintained with both the Coroner and Crown Prosecution Service.

8 Independent Chair and Overview Report Author

8.1 The Review Panel will be chaired and the Overview Report prepared by Chris Few, an Independent Consultant. Mr Few has chaired review panels and written overview reports on behalf of numerous Community Safety Partnerships, Local Safeguarding Children Boards and Local Authorities in connection with Domestic Homicide Reviews and Serious Case

Reviews. He has no personal or professional connection with any of the agencies and professionals involved in the events considered by this Review.

9 Domestic Homicide Review Panel

9.1 The Review Panel will comprise senior representatives of the following organisations:

- Staffordshire Police
- West Midlands Ambulance Service NHS Foundation Trust
- University Hospital of North Staffordshire NHS Trust
- North Staffordshire Combined Healthcare NHS Trust
- Stoke-on-Trent CCG (representing NHS England in respect of primary care services)
- Aquarius
- Stoke-on-Trent City Council
- ARCH (as advisor to the Panel)

10 Communication

10.1 All communication between meetings will be in confirmed in writing and copied to Graeme Drayton, Stoke-on-Trent City Council, to maintain a clear audit trail and accuracy of information shared. Email communication will utilise the secure portal established by Stoke-on-Trent City Council for that purpose.

11 Legal and/or Expert Advice

11.1 Graeme Drayton, Stoke-on-Trent City Council, in consultation with the Independent Review Panel Chair, will identify suitable experts who would be able to assist the Panel in regard to any issues that may arise.

11.2 However, the Individual Management Review Authors should ensure appropriate research relevant to their agency and the circumstances of the case is included within their report.

11.3 The Overview Report will include relevant lessons learnt from research, including making reference to any relevant learning from any previous DHRs and Learning Reviews conducted locally and nationally.

12 **Family Engagement**

12.1 The Review Panel will keep under consideration arrangements for involving family and social network members in the review process in accordance with the Guidance. Any such engagement will be arranged in consultation with the Police Senior Investigating Officer and, where relevant, Family Liaison Officer.

12.2 The Independent Review Panel Chair will ensure that at the conclusion of the review the victim's family will be informed of the findings of the review. The Responsible Authorities Group will give consideration to the support needs of family members in connection with publication of the Overview Report.

13 Media Issues

13.1 Whilst the Review is ongoing the Staffordshire Police Media Department will coordinate all requests for information/comment from the media in respect to this case. Press enquiries to partner agencies should be referred to the Police Media Department.

14 Timescales

14.1 The review commenced with effect from the date of the decision of the Chair of the Community Safety Partnership and should be completed and submitted to the Chair of the Responsible Authorities Group by 6 January 2015.

Appendix B

AGENCY RECOMMENDATIONS

Stoke-on-Trent City Council Housing (Cooperative Working):

a) That all relevant staff within Cooperative Working have up to date training in how to identify indicators of domestic abuse/violence and how to report or action these.

Staffordshire Police:

b) For Staffordshire Police to have a better understanding of the issues in relation to male victims of domestic abuse across its workforce.

c) For Staffordshire Police to engage with partners through the Domestic Abuse Steering Group to promote the reporting of Domestic Abuse from male victims and to ensure that the multi agency response is appropriate.

d) For Staffordshire Police to market and develop and understanding of domestic abuse within same sex relationships across its workforce.

e) For Staffordshire Police to develop strategies to raise the awareness and improve the compliance rate of DIAL completion and submission.