CONFIDENTIAL

OVERVIEW REPORT

DOMESTIC HOMICIDE REVIEW

8 - 2016

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June 2017

CONFIDENTIAL

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.

2 Summary of Circumstances Leading to the Review

2.1 The victim (Z) and perpetrator (R) were long standing friends and had lived together in Stoke-on-Trent for three years. In June 2015 emergency services received a call from R who

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

stated that he had found Z dead in the bath at their home address. R was arrested at the scene but released on Police bail whilst post mortem investigations were carried out.

2.2 The final post mortem examination report, provided in December 2015, identified that Z had died from drowning but had numerous old and recent injuries.

2.3 In April 2016, on the basis of Z's injuries and other evidence gathered by the Police, R was charged with murder.

2.4 On 11 May 2016 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.

2.5 In October 2016 R was convicted of murdering Z and sentenced to life imprisonment with a minimum term of 18 years.

2.6 HM Coroner for Stoke-on-Trent and North Staffordshire opened and adjourned an inquest pending the outcome of the criminal trial. That inquest will not now be reconvened.

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 June 2012 (when R was released from prison and moved in with Z) until the date of the fatal incident. 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	Z	R
Relationship	Victim	Lodger with Z
Gender	Male	Male
Age (June 2015)	69 years	59 years
Ethnicity	White British	White British

3.4 In conjunction with the areas for consideration outlined at Section 4 of the Statutory Guidance the Review specifically considered violence, abuse and neglect between two people in the same household who were not in an intimate relationship, and the effectiveness of support services.

4 Review Process

4.1 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.

4.2 Management Review Reports and Summary Information Reports were submitted by:

- Staffordshire Police
- University Hospitals of North Midlands NHS Trust
- NHS England North Midlands (in respect of primary care services)
- Stoke-on-Trent City Council Adult Social Care
- Stoke-on-Trent City Council IDVA Service
- West Midlands Ambulance Service
- National Probation Service
- North Staffordshire Combined Healthcare NHS Trust
- Arch North Staffordshire (In respect of domestic abuse of R's ex-wife)
- Staffordshire and Stoke-on-Trent Partnership NHS Trust
- Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership.

4.3 Consent to access his primary health care records was sought from R but not provided[3]. His GP declined to provide access without the consent of R. Access to those records by the Review Panel may have improved the Review Panel's understanding of what occurred and the reasons for that.

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

- Staffordshire and Stoke-on-Trent Adult Safeguarding Enquiry Procedures (June 2016)
- Staffordshire and Stoke-on-Trent Adult Safeguarding Enquiry Procedures (Working Draft - April 2015)
- Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership. Inter-agency Adult Protection Procedures (September 2010).

4.5 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 personal or professional connection with any of the agencies and professionals involved in the events considered by this Review.

4.6 The Review Panel comprised the following post holders:

- Detective Inspector Glyn Pattinson
  Senior Investigating Officer
  Staffordshire Police

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

[3] 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.

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

- Nathan Dawkins
  Commissioning Officer, Safer City Partnership
  Stoke-on-Trent City Council

- Kim Gunn
  Lead Nurse Adult Safeguarding
  NHS England North Midlands (in respect of primary care services)

- Rachael Fitton
  Adult Safeguarding Nurse Specialist
  NHS England North Midlands (in respect of primary care services)

- Karen Capewell
  Strategic Manager, Safeguarding, Quality and Commissioning
  Stoke-on-Trent City Council

- Mandy Francis
  Senior Adult Safeguarding Social Worker
  Stoke-on-Trent City Council

- Paula Brogan
  Domestic Violence Victim/Survivors Co-ordinator
  Arch North Staffordshire

- Robert Cole
  Safeguarding Lead
  West Midlands Ambulance Service

- Sarah Curran
  Adult Safeguarding Nurse
  University Hospitals of North Midlands NHS Trust.

4.7 In addition to the Scoping Panel Meeting the Review Panel met on two further occasions in September 2016 and April 2017 to consider contributions to and emerging findings of the Review.

4.8 This Overview Report was endorsed by the Review Panel on 20 June 2017 and forwarded to the Chair of the Stoke-on-Trent Responsible Authorities Group. On 10 August 2017 the report was presented to and endorsed by the Responsible Authorities Group.

4.9 Delay in referral of Z for consideration of a Domestic Homicide Review was a result of the time taken to confirm the cause of his death. Further delay in completion of the Review and its subsequent submission to the Home Office was necessary to secure comprehensive analysis of agency involvement and to facilitate engagement of Z's family with the Review.

5 Parallel Processes

5.1 The criminal investigation into the death of Z was conducted in parallel with this Review.

5.2 HM Coroner for Stoke-on-Trent and North Staffordshire opened and adjourned an inquest pending the outcome of the criminal trial. That inquest will not now be reconvened.

6 Family Engagement

6.1 Family members of Z were advised that the Review was taking place at its outset[5]. On 6 March 2017 the three daughters and ex-wife of Z met with the Independent Chair of the Review. Z's son was invited to this meeting or to meet separately with the Review Panel Chair but declined to do so.

6.2 Information provided by and the views of these family members are included within the body of this report[6]. The Review Panel is very grateful for their contribution to the Review.

6.3 The son and daughter of R referred to in this report were also informed of the review at its outset and invited to contribute. They declined to do so.

6.4 The ex-wife of R, referred to in particular at section 11 of this report and with whom the Review Panel would have liked to engage, died at the end of 2015.

6.5 R was advised of the review and asked for consent to access his primary care records. No response was received.

6.6 Members of Z's family were provided with advocacy from AAFDA (Advocacy After Fatal Domestic Abuse) and given sight of this report and the Action Plan prior to their submission to the Home Office.

[5] Establishment of contact with family members was through the Police Family Liaison Officer who hand delivered and explained letters from the Review Panel Chair.

[6] Family members were asked if they would wish a pseudonym to be used for Z in this report. They collectively stated that they did not and initials, having no relationship to those of individuals, have therefore been used to anonymise this report.

THE FACTS

7 Background of Z and R

7.1 The Review was informed by the Police that Z and R had been friends for over thirty years and that R was godfather to some of Z's children. They had both been heavy users of alcohol and over the years had periodically lived together at various addresses. There was no intimate relationship between them.

8 Victim – Z

8.1 Z was born in Stoke-on-Trent in 1946. He was one of four children, with two sisters and a brother. He worked throughout Britain and occasionally abroad as a Welder. During his employment he suffered a serious accident resulting in two of his fingers being amputated and him being provided with an industrial injuries pension.

8.2 Z had been married twice, having two children from the first marriage and four more children before the breakdown of his second marriage 30 years ago.

8.3 Z had a long history of alcohol misuse. He had convictions for violence and criminal damage dating back to 1965. His last conviction was in July 2010 when he was sentenced to fourteen months imprisonment for threatening and holding a knife to the throat of another driver during a road rage incident. He was released on licence in November 2010 and the licence expired in June 2011.

8.4 In November and December 2010 Z visited his GP on three occasions regarding an infection to his right leg. Z reported that he drank 3-4 alcoholic drinks a day on 2-4 occasions a month and his GP recorded 'poor compliance and self care'. By the third appointment the condition of Z's legs was noted to have improved.

8.5 Z's daughters described him as a wanderer who drifted in and out of their lives. During the period within the scope of this Review only two of them were in contact with him.

9 Perpetrator - R

9.1 R was born in Stoke-on-Trent and raised by his mother and step father. He has one full brother and three half-sisters.

9.2 In 1983 R married S. They had two children together. R is reported by his family to have had a previous marriage, from which he had three children and another previous relationship from which he had a further child

9.3 In 1993 R and S divorced but they remained in a relationship until August 2011, when R was imprisoned for stabbing his next door neighbour.

9.4 R has a number of other convictions, including for assault, possession of an imitation firearm, and possession of an offensive weapon, dating back to 1996. In respect of the imitation firearm offence, which involved threats towards neighbours, R was the subject of MAPPA consideration as Category 2 (Violent) Offender on four occasions in 2005-6.

9.5 Between 1996 and 2002 R was referred by his GP to North Staffordshire Combined Healthcare NHS Trust (NSCHT) on five occasions for anxiety. Of the 16 appointments offered R attended only three, the last of these being in 1996.

9.6 In December 2010 R was referred by the Probation Service to the NSCHT Single Point of Access in relation to increased aggression and increased alcohol use. R reported that since he had come out of prison five years previously he had been unable to leave the house and had been having panic attacks, causing him to pass out. R was recorded as stating that he tended to forget what had happened in the previous couple of hours and suffered from palpitations which had been diagnosed as angina.

9.7 R stated that he had been prescribed diazepam by his GP to enable him to leave the house and that he hoarded these to take with vodka on the day of his appointments with his Probation Officer. He further stated that mixing the tablets with alcohol made him feel very violent.

9.8 R was offered three appointments but did not attend any of them and was discharged in May 2011. In the absence of access to R's primary care records it is unknown whether he continued to be prescribed diazepam or if he continued to misuse this with alcohol.

9.9 In December 2011 R was released on licence from a 12 month sentence for the assault on his neighbour referred to above (see 9.3). Whilst in prison R was considered at MAPPA (as a Category 3[7] Offender) following a Probation Service referral but it was concluded that continued MAPPA involvement would not provide any added benefit. R was offered referrals to mental health and substance misuse services but declined to engage with these.

9.10 Five days after his release R was again detained and recalled to prison until June 2012 as he had not co-operated with his licence conditions and had absconded.

10 Summary of Events

10.1 On his release from prison in June 2012 R moved into the house which Z rented privately. The National Probation Service advised the Review Panel that this was on the basis that he had nowhere else to go.

10.2 Z's daughters stated that Z and R had been friends for around 40 years and had lived together previously. This arrangement generally ended when they got into trouble together but was later renewed. They had first met when they started working together, with Z teaching R to weld. Alcohol misuse was a common issue for both of them.

10.3 Z was stated to be very loyal to R. R was stated to be violent, with lots of people scared of him – but not Z.

10.4 One of Z's daughters stated that she would only visit Z's home, when R was not there, describing R as disgusting towards women. Z's daughters expressed the view that they did not really know what was going on between Z and R on a day to day basis.

10.5 During the period under review there were eight episodes of professional involvement with Z and / or R prior to the fatal incident.

[7] Category 3 because the current offence "possession of offensive weapon" (knife) was not MAPPA eligible but there was previous offending and sufficient concern to suggest a benefit in MAPPA considering the offender.

11 Domestic abuse by R of his ex-wife

11.1 In July 2012 R's ex-wife (S) self-referred to Arch Domestic Violence Outreach Service. She stated that following the release of R from prison in June 2012 he had begun harassing her and that threatening voicemail messages had been left by friends of R, acting on his behalf.

11.2 She also reported that R was very abusive during their relationship and had slashed her with a knife, strangled her, burnt her with cigarettes and threatened to kill her. She explained this would always happen when she tried to leave, that he was very controlling and had isolated her throughout their relationship.

11.3 S further stated that R had done things of a sexual nature to her while she was asleep, telling her what he had done when she woke up, and that he had killed her cat by strangulation then thrown it on the bed while she was asleep. S added that R had been abusive to his first wife and had recently been released from a prison sentence for assault on a female neighbour. R was reported to misuse alcohol, which exacerbated his violence.

11.4 This was the first time that S reported abuse by R to any agency or professional.

11.5 A CAADA[8] risk assessment was completed and S was referred to MARAC where her case was heard later in July 2012. Following the MARAC S was provided with continued support by Arch over the following 9 months. This included a referral to Savana[9] for counselling, liaison with housing to secure a change of address, provision by the Police of Skyguard[10] services and arranging engagement with a Stoke-on-Trent City Council IDVA[11]. S was also referred to the Arch Freedom Programme which she completed.

11.6 Following the referral from Arch a Stoke-on-Trent City Council IDVA supported S in obtaining a non-molestation order against R.

11.7 The support provided to S as a victim of domestic abuse was appropriate and well delivered by Arch and Stoke-on-Trent City Council.

11.8 Details of the abuse reported to Arch by S were included in the MARAC referral and logged on the Police Guardian public protection database.

11.9 Although there was no direct report to them from S at that time this indicates that the Police were aware of the alleged abuse. At the time of the referral to MARAC there was however no process in place to record crimes that were reported in the context of a MARAC referral or identified at MARAC. These crimes were not therefore recorded or investigated.

11.10 The Police advised the Review Panel that consequent to a recent review of the MARAC system, crime recording has been incorporated into the front door process for receiving MARAC referrals from all agencies. For matters reported within a MARAC itself all MARAC chairs are now aware that any previously unreported crimes require appropriate recording on crime systems.

[8] Coo-ordinated Action Against Domestic Abuse. .This organisation has now been renamed Safelives.
[9] Savana is a charity providing support to those who have been subjected to sexual violence.
[10] Skyguard provides a range of personal safety devices and an associated monitoring service.
[11] Independent Domestic Violence Advisor. The IDVA model currently provided by Stoke-on-Trent City Council, supports only victims going through the court process. This model is non-standard and does not follow the Safelives model of IDVA provision, which provides support to all high-risk victims of domestic abuse. The IDVA service in Stoke-on-Trent will be brought into line with the Safelives model when the new contract for domestic abuse services across Stoke-on-Trent and Staffordshire commences.

11.11 The information regarding abuse to which S had been subjected was held only on the 'Guardian' system which restricted its accessibility and there is no indication that it was accessed to inform responses to subsequent complaints from S or the later incidents involving alleged abuse of Z.

11.12 On 20 November 2012 R's GP referred him to the (then) community alcohol service provider (Aquarius), but R did not attend the appointment offered or otherwise engage with the service. His case was therefore closed the following month.

11.13 In June 2013 S reported to the Police that R had breached the non-molestation order. This was found to be a chance encounter and no further action was taken.

11.14 In September 2013 S reported to the Police that R was continuing to breach his non-molestation order. Z informed the Police that he had been driving with R around at the time of the allegation, providing an alibi for him as a result of which no further action was taken.

11.15 In November 2013 S again reported that R had breached his non-molestation order. Z again provided an alibi, stating that he was driving with R at the time of the allegation, and no further action was taken.

11.16 That no action was taken against R for breach of the non-molestation order in 2013 was a consequence of Z providing R with alibi on 2 occasions. It is possible that more concerted investigation of the allegations, including research into the use of communication devices, may have supported or more robustly refuted the alleged breaches. Pursuing these avenues would have been more likely if the full extent of the abuse reported to Arch by S had been subject to a criminal investigation in 2012 and the information held more accessibly.

12 Injuries to Z – March 2013

12.1 In March 2013 Z was treated at the Royal Stoke Hospital (University Hospital of North Midlands NHS Trust – UHNM) for lacerations to his left forearm and right fingers, reported by him to have occurred after drinking two bottles of vodka. He stated that he could not recall how the injuries happened but when he woke up he found the glass of a cupboard broken. Z was noted by the hospital to also have a bruise to his face. Two weeks later Z visited his GP surgery and had the stitches removed by a Practice Nurse. He told that Nurse that he had sustained the injuries when he fell on a bottle.

12.2 The Nurse completed an alcohol screening assessment with Z who was recorded as drinking more than 10 alcoholic drinks on a typical day consisting of at least a bottle of vodka and cans of lager. Intervention for alcohol consumption was offered but declined by Z. When Z returned to the GP surgery for a further check-up in April 2013 he was offered but again declined intervention regarding his alcohol misuse.

12.3 Z's family members were not aware that he had sustained injuries in March 2013.

12.4 There was no information available to the health professionals involved to suggest that Z was at risk of inflicted injury. There were inconsistencies in the accounts provided by Z to the hospital and the Practice Nurse at his GP surgery but the injuries were not inconsistent with him having fallen on glass whilst drunk. It cannot now be established if the injuries to Z were not accidental.

12.5 In 2013, and subsequently in 2014, Z presented as having a significant alcohol misuse problem and the focus on offering services to address this was appropriate. That Z declined to engage with this permissive provision was within his capacity to decide and there is no indication of Z having any contact with substance misuse services in Stoke-on-Trent or Staffordshire at any point.

13 Medical Treatment of Z for Vascular Problems

13.1 In March 2014 Z attended his GP surgery and complained of leg pain. At that time it was recorded that his alcohol consumption consisted of 2-3 bottles of vodka and 20-30 cans of beer a week'. The GP encouraged Z to reduce his alcohol intake.

13.2 In April 2014 Z attended the Royal Stoke Hospital Emergency Department and was found to have an ischaemic right foot with gangrene. He was admitted and had a partial amputation of his right foot. Outpatient follow up by the hospital Haematology and Vascular Teams was arranged on his discharge.

13.3 Staff from Staffordshire and Stoke-on-Trent Partnership NHS Trust (SSOTP) District Nursing Service visited Z regularly until October 2014 to change his dressings. None of the staff who visited Z recorded any indications of violence or other safeguarding concerns.

13.4 Z's daughters described the District Nursing Service staff who changed Z's dressings as making very short visits to undertake this and were of the view that R would have ensured that they were not given any cause for concern about Z's welfare.

13.5 Z recovered independent mobility without the use of walking aids. It is however clear from correspondence within his medical records that he failed to attend numerous appointments offered by the Royal Stoke Hospital Haematology Team during this period to address his vascular problems, despite being repeatedly warned by the hospital and GP Practice staff that this and non-compliance with his medication regime posed risks to his health.

13.6 The significant efforts made by a practice Nurse at Z's GP surgery to secure his engagement were particularly commendable.

13.7 One of Z's daughters reported that she hand delivered a letter to Z from the GP urging him to engage with the anti-coagulation clinic at the Royal Stoke Hospital. He said he would go but she was not sure that he would do so.

13.8 She advised that Z did not like doctors or medical services and stated that she believed this to be the result of him being sectioned under the Mental Health Act and undergoing ECT at the request of his mother when he was a teenager. His mother had described him as "not being right in the head" after he fell off a bike when aged 18.

13.9 A daughter of Z further advised that when Z came out of prison the last time (in 2010) he did not have a bank account. She had therefore allowed him to use a bank account that she was not using and provided him with the associated bank card so that he could use it to receive his pension. When Z was in hospital having his foot amputated (in April 2014) he had disclosed to his daughter that R had the bank card and was withdrawing money from the account.

13.10 Z's daughter believed that R was using Z's money for his own purposes and cancelled the bank card, saying it was lost. When Z was discharged from hospital she took money out and

gave it to Z in cash but when she continued to refuse to provide Z with a new bank card he opened his own account and had his pension paid into that.

13.11 Z's daughters remarked that by the middle of 2014 it was clear that Z was afraid of R; he seemed to have lost his confidence when his foot was amputated and their relationship changed. Z would not however do anything about his situation with R.

13.12 Z's daughters were of the view that Z did not need a carer as a result of having his foot amputated and was well able to walk 2-3 miles to visit his children's addresses. They were therefore surprised to learn at the trial of R in 2016 that R had been claiming Carer's Allowance in respect of Z for about 6 months prior to his death and could not think what he would have been doing to provide any care.

13.13 Carer's Allowance is administered by the Department for Work and Pensions and is provided on the basis of an online application process. The Review Panel concluded that R would have met the criteria for the payment of this allowance if he applied for it.

14 Arrest of R – August 2014

14.1 In August 2014 R was stopped whilst driving in Stoke-on-Trent and arrested for drink driving and possession of a knife. He was seen in custody by the NSCHT Criminal Justice Mental Health Team and reported drinking 2-3 litres of vodka a day. He acknowledged a history of violence but stated it was "his other self" and that he had no recollection of the actions his "other self" took. R further stated that he had seen psychologists and psychiatrists about this but they had not helped. He declined any further referrals.

14.2 Mental health service providers in Stoke-on-Trent and Staffordshire have no record of R accessing such services since 1996 when he was seen by North Staffordshire Combined Healthcare Trust (NSCHT) staff for anxiety on three occasions. When further referrals were made, up until 2002, R did not engage with the service. In the absence of access to R's primary health care records the possibility that he accessed such services elsewhere in the country has not been eliminated.

15 Injury to Z – November 2014

15.1 On 19 November 2014 Z attended his GP surgery. He was limping but the stump of his right foot was healthy. Z agreed to an Orthotic referral as he was wearing ordinary shoes. His medication was reviewed and advice given on alcohol consumption.

15.2 During the appointment Z was noted to have a bony swelling and bruise to his right jaw. He stated that he had a fall on a bus 3 weeks previously. Z was advised to have an x-ray and provided with an x-ray card and information on where he could have this done.

15.3 The facial injury sustained by Z in October / November 2014 was not inconsistent with the explanation given by him to his GP.

15.4 There are no results of the x-ray in Z's GP records, suggesting that he did not follow the advice from his GP.

15.5 NHS England advised the Review Panel that providing patients with an x-ray card for them to access the service at their convenience is established practice and it would have been Z's responsibility to attend for the x-ray. The Panel were informed and accepted that it is not reasonably practicable for GPs to proactively chase up whether patients have attended for x-rays that are not urgently required.

15.6 Following the death of Z a number of relatives were interviewed as part of the Police investigation. Three of Z's relatives reported seeing an injury to his cheek around November 2014 and being told by Z that he had fallen over, before changing his story and saying that 'some Asians' were responsible[12]. Z eventually told his son that R had caused the injuries. Neither Z nor any of his relatives reported this to any agency at the time.

15.7 A daughter of Z advised the Review Panel Chair that in November 2014 Z arrived at her house late in the evening with a facial injury and saying that he had slept rough for a couple of nights. After spending a night there and then a further night at another daughter's address Z went to stay with their brother for about two weeks. Z told his son that R had hit him and said that he could not go back home until he had received money from his disability pension. He also said that R was opening his mail.

15.8 During this period Z's children were keeping in touch with each other about what Z was doing. Two daughters of Z considered reporting the assault on Z by R but Z was petrified of this happening and they believed that he would have denied it if asked.

15.9 None of Z's family saw him in person after November 2014. There was however some telephone contact and Z had visited one daughter's address in March 2015, although she was out at the time.

16 Assault on Family Member by R – February 2015

16.1 In the early hours of 12 February 2015 R's daughter reported to the Police that R was at her address, was drunk and had hit her partner.

16.2 When Police Officers arrived they were informed that R had already left the address in a vehicle driven by Z. It was reported that R had drank too much, become abusive and slapped his daughter's partner whilst being escorted away from the premises. The partner of R's daughter declined to support an investigation and no further action was taken by the Police Officers.

16.3 Initially this incident was correctly logged as a "family domestic incident." As such a crime should have been recorded and a Domestic Incident Assessment Log (DIAL[13]) should have been completed by the attending Officer. The incident was however then incorrectly finalised as a "family incident no-crime" with no crime report recorded and consequently no DIAL form completed.

[12] Z's children related to the Review Panel Chair that he was often racist in his speech and came across as such although at a personal level he got on well with a number of BME acquaintances.

[13] The DIAL form is the means by which Staffordshire Police assess the level of risk to a victim of domestic abuse; they are also used to record additional information and professional judgement. The risk score on the DIAL form is used to determine the level of response to the incident.

16.4 When interviewed for this Review the attending Police Officer stated that as only a moment of passing discomfort was caused the Officer believed that a crime report was not required. This belief is incorrect and has been addressed with the Officer.

16.5 The Police advised the Review that new procedures put into place across Staffordshire and Stoke-on-Trent in January 2016 changed incident classifications by removing the "family incident no crime" option. All incidents of this nature would therefore require a DIAL risk assessment to be completed, regardless of whether a crime was recorded. However, the pressure on resources resulting from this change had subsequently prompted the piloting in Stoke-on-Trent of an arrangement where the use of DIAL forms for domestic incidents involving family members who are not intimate partners is now at the discretion of the attending Officer.

16.6 Concerns regarding this retrenchment have been identified in the context of another Stoke-on-Trent Domestic Homicide Review and brought to the attention of the Stoke-on-Trent Responsible Authorities Group from that review. The Responsible Authorities Group is securing assurance from Staffordshire Police that this initiative is not detrimentally affecting the recognition of and provision of support to victims of violence.

16.7 This incident did not involve offences against Z. It does however underline that R's propensity for violence, as indicated by his convictions and the information shared in July 2012 by his ex-wife remained present.

17 Assault on Z – May 2015

17.1 In the early hours of 5 May 2015 an ambulance was called by the occupant of an address in Stoke-on-Trent. It was reported that Z was there and had been cut with knives by 3-4 people. The attackers were reported to not be present.

17.2 Police Officers attended with the ambulance and were informed by Z that he had gone out for a walk and a cigarette and that he was attacked outside by two or three people with a knife. The occupant of the address stated that when Z returned he noticed blood on him and called the ambulance.

17.3 Z was taken to Emergency Department of the Royal Stoke Hospital where he was found to have five lacerations to his shoulders and back. He was alert and orientated and his vital signs remained stable. The decision was made to admit Z to the clinical decision unit for monitoring and treatment of his wounds.

17.4 At the hospital Z provided a statement to the Police that he was verbally abused in an Asian language outside the address and set upon by four to five males who stabbed him several times. R and the occupant of the address provided statements which were consistent with that of Z, but were vague.

17.5 CCTV coverage of the alleyway where the assault was stated by Z to have occurred did not show Z or any males hanging around. A neighbour did however state that she heard the sound of foreign voices shouting in the alleyway around the time of the incident.

17.6 Later on 5 May 2015 R's daughter contacted Stoke-on-Trent City Council Adult Social Care Emergency Duty Team (EDT) expressing concern for the welfare of Z. She explained that R lived with Z, who was at that time a patient in the Royal Stoke Hospital consequent to him having been stabbed, as his friend and main carer. She stated that that R was a "nasty and violent man", particularly when he had been drinking alcohol. She said she had previously

seen Z with bruising to his face and arms and that she strongly suspected the injuries had been caused by R although she had no evidence to support this. She also had concerns that Z was losing weight, was extremely neglectful about his personal care and was "a shadow of the man he once was" and suggested that R was financially abusing Z.

17.7 An EDT Social Worker spoke with Z on the telephone. He stated that the Police had been contacted, that the stabbing was nothing to do with R and he had no problems with R. Z said that he was not being hurt by R or exploited by R and did not want any further enquiry to be made.

17.8 Notwithstanding the position expressed by Z the concerns raised by R's daughter were followed up on 6 May 2015 by an Adult Social Care Locality Team Senior Social Worker. Following confirmation with the Police and hospital that Z had been injured this Social Worker made an Adult Safeguarding referral to the MASH[14] (under the Staffordshire and Stoke-on-Trent Adult Protection Procedures).

17.9 Z was discharged from the hospital on 7 May 2015. Hospital records indicate that he was discharged with his "carer", although the person's name was not recorded. Z's GP was advised of the admission and that Z's stitches should be removed seven days later.

17.10 UHNM advised the Review that nothing was recorded within the medical or nursing records to suggest that there was any violence, abuse or neglect between R and Z. The EDT record however states that the Clinical Decision Unit Doctor was assured by Z that he felt safe to return home.

17.11 This record entry must reflect some contact between the EDT Social Worker and hospital staff although there is no record of this in the hospital notes. The Review Panel was informed that not all conversations are recorded in the notes but that any concerning an adult safeguarding issue should have been. It has not been possible to establish why this was not recorded.

17.12 On Friday 8 May 2015 the MASH shared the outcome of checks conducted with other agencies with the Locality Team Senior Social Worker, along with contact details of the Police Officer investigating the stabbing incident.

17.13 On 11 May 2015 a strategy discussion was held in the MASH to share information in relation to the referral. It was agreed that the referral required a joint Adult Social Care and Police investigation.

17.14 In the early hours of 12 May 2015 one of R's sons called the Police. He stated that he wished to remain anonymous but that he had an issue with his father, R, and that he could not deal with it any longer. He stated that his father had stabbed Z the previous week and was 'losing the plot'. He stated that R was currently sitting by himself imagining he was talking to a friend although there was nobody there.

17.15 This call was referred to a Police supervisor who made telephone contact with R's son and was advised that R was remaining at his address and had gone to bed. No immediate safeguarding concerns were identified and R's son was asked to re-contact the Police if R woke up and he had any further concerns. The supervisor emailed details to the Investigating

[14] The Staffordshire and Stoke-on-Trent Multi-Agency Safeguarding Hub **(**MASH) is a co-location arrangement for a number of teams involved in safeguarding children and adults. These include:

- Stoke-on-Trent City Council Adult Safeguarding Team
- Staffordshire Police Public Protection.

Officer for the stabbing incident with a direction to contact the MASH regarding Adult Social Care involvement as well as following up the information provided regarding the cause of Z's injuries.

17.16 This was an appropriate response to the reported concerns about R's mental health.

17.17 Later that day the Police Investigating Officer visited R's son who stated that he had not witnessed the incident, but confirmed that his father had earlier admitted to him that he had stabbed Z. R was present at the address during this visit. He was noted to be acting normally and no concerns for his mental health were identified. R also did not present as having any mental health issues when spoken to by the Investigating Officer later that day.

17.18 On 13 May 2015 the Police Investigating Officer and Locality Team Senior Social Worker discussed the case. During this conversation the Social Worker advised that she would be visiting Z and would consider any intervention required by R in relation to his mental health.

17.19 Also on 13 May 2015 an Adult Safeguarding Referral[15] in respect of Z was forwarded to the MASH by the Police Investigating Officer. This was logged as being part of the current investigation.

17.20 When interviewed as part of this Review the Police Investigating Officer advised that the Adult Protection Referral was made, even though there was an open Adult Safegurding Investigation, to formalise the information being passed regarding the circumstances of the incident. They were however unclear as to the actual process surrounding when and why an Adult Protection referral should be submitted.

17.21 On 15 May 2015 R's son provided a statement of evidence to the Police.

17.22 There was a delay of 3 days from Officers speaking to R's son and a statement of evidence being obtained. The delay appears to reflect efforts to build a good rapport and give R's son the confidence to provide an evidential statement when in his initial contact with the Police he had stated that he did not want his father to know he had initiated that contact.

17.23 Z was then revisited by the Police but denied that R or any other friend was involved in the assault on him. He stated that R had money from him as his carer, but he was not having any more than he should.

17.24 On 16 May 2015 R was arrested for Assault with intent to cause Grievous Bodily Harm, on the basis of the information provided by his son. Whilst at the custody suite R was seen by a health care professional. He was deemed fit for detention, with no appropriate adult required for interview. R denied assaulting Z and was subsequently released with no further action by the Custody Sergeant.

17.25 For this Review the Police report author examined the evidence available to the Custody Sergeant. He concluded that the decision not to refer the matter to the Crown Prosecution Service (CPS) and to take no further action was appropriate. It was noted that Z was spoken to on several occasions by Police and Social Care and he gave the same account of events which did not implicate R, the witness with whom Z and R were drinking gave a similar account to that given by Z and R, CCTV did not show Z or a group of males, but an independent witness did hear foreign voices at the relevant time, which supported Z's account.

[15] On form AP1 – the referral form specified in the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership. Inter-agency Adult Protection Procedures (September 2010).

17.26 The only available evidence to say that R was responsible for the injuries to Z was provided by R's son following a reported admission to him by R.

17.27 There is no record of contemporaneous discussion between the Investigating Officer and the Locality Team Senior Social Worker regarding the arrest, interview and subsequent release of R, or the safeguarding implications of releasing R to return to Z's address. A telephone message providing an update was left by the Police Investigating Officer on 18 May 2015 and recorded on Adult Social Care systems.

17.28 Between 18 and 22 May 2015 the Locality Team Senior Social Worker made visits to Z's home address but no reply was received from him. Contact details were left and on 22 May Z telephoned the Social Worker. Z reiterated that he did not need any Adult Social Care intervention and stated that R's daughter had always held a grudge against her father. He maintained that he was safe and well but agreed to meet the Social Worker face to face in the week commencing 1 June 2015[16].

17.29 No meeting between the Senior Social Worker and Z took place during the week commencing 1 June 2015 and although the Adult Social Care case remained open until the death of Z was notified to that organisation no further action was taken during the intervening period.

17.30 Adult Social Care informed the Review Panel that on the basis of the information provided by Z, whom she had no reason to think lacked capacity, and having no other information which would indicate a high level of risk, the Senior Social Worker was not overly concerned by Z. She therefore viewed an arrangement to see Z on her return from holiday appropriate.

17.31 Adult Social Care advised the Review Panel that follow up with Z had been overlooked as further urgent work came in and that there was no indication of managerial oversight of the case prior to the death of Z[17]. In this regard Adult Social Care also advised the Review Panel that in parallel with the introduction of the Care Act in April 2015 Adult Social Care had moved to a new way of working and that there was a full re-organisation of the service in early June 2015. This involved a move from three to eight smaller locality teams, each aligned with a GP surgery. For the Senior Social Worker this meant a move to a specialist dementia role with a change of manager and office base.

17.32 The Review Panel recommended that:
The Stoke-on-Trent Responsible Authorities Group should highlight to all partner agencies the learning from this review about the importance, when implementing significant organisational changes, of ensuring that robust arrangements are in place for maintaining continuity of care and other service provision, particularly to vulnerable individuals.

17.33 Overall it is apparent that the joint (Police and Adult Social Care) investigation agreed at the MASH strategy discussion on 11 May 2015 in fact consisted of two separate strands working in parallel.

17.34 The Review Panel was advised that the MASH would only decide if it was to be a single, joint or multiple agency approach and it would then be left to the workers in the agencies to take it forward, with Adult Social Care having lead responsibility[18] for this. It is however unclear how

[16] Adult Social Care advised the Review Panel that the Social Worker had been on leave until the week commencing 1 June 2015.
[17] Adult Social Care advised the Review Panel that as a Senior Social Worker the level of managerial case oversight expected would have been less than that provided for other team members.
[18] In accordance with the Care Act 2014.

effectively this was communicated to the front line staff in Police and Adult Social Care who would conduct the investigation.

17.35 In April 2015 new Adult Safeguarding Procedures, providing for a more coherent and person centred approach to Adult Safeguarding, were introduced by the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership (SSASPB), albeit at that time in working draft form, to coincide with implementation of the Care Act 2014. These replaced the 2010 Adult Protection Procedures. The new procedures were ratified by the Partnership Board in July 2016 but are subject to regular updating to reflect, for example, learning from Domestic Homicide Reviews.

17.36 Both the 2010 procedures and those introduced in 2015 include that where a joint criminal /Adult Safeguarding investigation is being conducted, interviews with the adult who is subject of the referral should be jointly conducted by the Police and Social Care / CMHT wherever practicable. The 2015 procedures go further, providing detailed and comprehensive guidance on the planning and conduct of such investigations.

17.37 The 2015 working draft procedures[19] were cascaded by the SSASPB to partner agencies. Within Adult Social Care the Review Panel was informed that the service provided a copy of the safeguarding procedures to all teams via email and training developed by the safeguarding team was delivered to all staff, supported by attendance at city wide managers meetings by the Safeguarding Team Manager to discuss the preparation required for introduction of the Care Act.

17.38 The Review Panel were advised that within the Police further dissemination was by an email; drawing the attention of staff to the new procedures.

17.39 Notwithstanding this, when the Police Investigating Officer and a colleague who had worked with them were interviewed as part of this Review it appeared that the benefit of a joint visit to Z was not fully understood by these practitioners.

17.40 From the Adult Social Care perspective the Review Panel was informed that the Social Worker had assumed there would be a Police led investigation and that Adult Social Care had a secondary role, being involved only because Z had care and support needs. In this regard it appears that the responsibility of Adult Social Care to ensure that plans to safeguard and support Z were promptly developed and implemented was not recognised.

17.41 The Review Panel was advised that to promote the effectiveness of Adult Safeguarding responses, including joint working, arrangements now include[20]; co-location of all Adult Social Care Teams to make oversight of safeguarding cases much clearer, twice yearly Strategic Manager safeguarding briefings for all assessment and care management staff which include learning from Domestic Homicide and Safeguarding Adult Reviews, as well as ad hoc meetings to address specific concerns. Recent examples of these have included, joint working with the Police and safeguarding enquiries regarding people in positions of trust. Also, that Police led workshops have been provided to Adult Social Care staff regarding joint investigations.

[19] And subsequently the ratified version of the procedures in July 2016.

[20] Other arrangements are that:

- The Safeguarding Senior Social Worker spends time with each Locality Team on a weekly basis.
- The Adult Social Care Safeguarding Team Manager attends monthly management meetings with all other Team Managers
- A regular safeguarding newsletter is produced and circulated to City Council staff.

17.42 In October 2016 the SSASPB launched a new website on which the current version of the Adult Safeguarding Procedures is held, and updated as revisions are made. The SSASPB is actively promoting the practice of agencies providing a link to this rather than holding potentially out of date versions themselves. There is however evidence that this process is not currently complete.

17.43 In January 2017 sampling of the websites owned by statutory partner agencies in Stoke-on-Trent identified none that had the most recent revision of the Adult Safeguarding Procedures[21] and that the 2010 and 2015 (working draft) procedures were commonly available, directly or through links from out of date policy documents.

17.44 The Review Panel recommended that:
The Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board should proactively raise awareness of the current local Adult Safeguarding Procedures and seek assurance from all partner agencies that relevant practitioners understand their responsibilities and are appropriately applying the procedures. This should specifically include reinforcement that:

1) where it has been decided that a joint investigation is required the Social Worker, the Police Officer and all other professionals involved must clearly plan who is to undertake which aspects and conduct at least an initial joint visit; and

2) where a single agency enquiry has been agreed, if there is concern around potential coercive control then arrangements must be made for a face to face meeting to take place. Such a meeting should be undertaken by two professionals.

17.45 On 28 May 2015 Z attended his GP practice for removal of the sutures and was seen by a Nurse Practitioner and a GP. It was noted that the sutures should have been removed 7 days following insertion but Z didn't attend the surgery until this appointment. One of the wounds was showing signs of being infected and it was thought this may need incision and drainage. The GP removed the sutures and issued a prescription for antibiotics. During this consultation, Z asked for his foot to be reviewed as it was painful. On examination a large necrotic area was observed. This was swabbed and dressed. There were concerns from the GP and Nurse that the District Nurses would not be able to manage the wound and that specialist input may be needed from the Tissue Viability Team along with a referral back to the Vascular Team. An appointment was made for Z to see the Nurse Practitioner the following day.

17.46 On 29 May 2015 Z did not attend for his appointment with the Nurse Practitioner. The Nurse phoned Z twice that day regarding his appointment but there was no answer so she had left voicemail messages. The Nurse tried to contact Z several more times over the following days with no success and therefore wrote to him regarding the concerns about his foot. The last attempt to contact Z was on 19 June 2015 but again there was no response to her calls.

17.47 Z's family were not aware of the assault on Z in May 2015 until told about it after his death.

18 Allegation by R of Theft - June 2015

[21] University Hospitals of North Midlands NHS Trust advised the Review Panel that the 2015 and subsequently revised procedures were made available to staff through their 'intranet' pages and that these changes were disseminated via communication bulletins and their safeguarding training.

18.1 On 17 June 2015 R called the Police and stated that his son had used his bank card to withdraw £300 from his account, which he wanted to report this as a theft. During the call R made reference to his son having called the Police about him in May 2015. When visited R stated that somebody had taken his card and pin code, used it to take out money and then returned it. There was however no evidence to support this allegation or to identify who had made the withdrawal. The report was therefore filed as undetected.

19 Murder of Z - June 2015

19.1 On an afternoon towards the end of June 2015 emergency services received a 999 call from R, who had stated that he had found his friend, Z, drowned in the bath at their home address with the taps still running.

19.2 West Midlands Ambulance Service and Staffordshire Police attended the property where they found Z dead in the bath.

19.3 R was at the scene and talked incessantly about a night out with friends in Stoke-on-Trent the evening before, who he was with and how poorly Z had been recently. R's general demeanour was suspicious and he was arrested.

19.4 R was interviewed and provided an account of his whereabouts in the period leading up to discovery of Z's body. R was then released on Police Bail for further enquiries to be completed, specifically around forensic pathology.

19.5 On 28 and 29 June 2015 a Post Mortem examination of Z was conducted by a Home Office Forensic Pathologist. The pathologist noted injuries and underlying conditions but was unable to give a cause of death without further pathological investigation.

19.6 On 21 December 2015 the Home Office Forensic Pathologist concluded that the cause of death was drowning but identified that Z had 121 injuries including damage to his brain, a broken nose, and fractured ribs. Other expert pathologists provided evidence that Z had sustained injuries between 12 and 36 hours prior to his death.

19.7 On 11 April 2016 R was re-arrested and charged with murder.

19.8 At the trial of R a neighbour gave evidence that on the day before Z's death was reported he had been told by R that Z was a "nonce" (sex offender) and had been present when R asked Z to confirm that he was a 'nonce', to which he replied "yes". The neighbour stated that R then told Z that he was going to kill him that night. In relation to this the neighbour stated that he did not take the threat seriously and thought that it was "the beer talking".

19.9 Z's family did not know that R had called him a 'nonce' until told about it after his death. They are aware that the only people who had used this term in respect of Z had been told by R that Z was a 'nonce'. They believe that R had told people this as a way of isolating Z.

FINDINGS AND CONCLUSIONS

20 Domestic Abuse / Adult Safeguarding

20.1 The definition of domestic abuse applicable in Stoke-on-Trent, 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…."

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

> "…a member of the same household…"

20.3 Accordingly, although the murder of Z by R falls within the scope of this Domestic Homicide Review, no violence towards or abuse of Z by R would meet the criteria for a domestic abuse response. In a previous Stoke-on-Trent Domestic Homicide Review[22] 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. The 2017-2020 Domestic Abuse Strategy for Staffordshire and Stoke-on-Trent will however set out a joint vision, approach and aim for addressing domestic abuse which will encompass a broader definition and the action plan for its implementation will include consideration of groups not currently covered by the Government guidance.

20.4 Adult Social Care confirmed to the Review Panel that Z fell within the Adult Safeguarding Procedures criteria because of his amputation, other complex health needs and by having a carer. It was therefore appropriate that the one occasion on which abuse of Z by R was alleged was responded to under the Adult Safeguarding Procedures.

20.5 Adult Social Care confirmed that R was never formally assessed as a carer for Z. In this respect that organisation was unaware of Z regarding R as his carer, or of R assuming that role, until the referral on 5 May 2015. It would then not have been appropriate to offer or conduct a carer's assessment in the context of the Adult Safeguarding Investigation and the assessment was not concluded prior to the death of Z.

21 Capacity

21.1 A principle of the Mental Capacity Act 2005 is that every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise. All professionals who had involvement with Z during the period under review correctly presumed capacity as there was no information to suggest otherwise.

21.2 Z's children were clear that Z always had capacity to make decisions but thought that his fear of R had influenced some of the decisions which he had made.

21.3 When dealing with professionals Z consistently denied any threat or harm to himself by R and declined any involvement or intervention. This mirrored Z's response to earlier offers of intervention to address his excessive alcohol use and his lack of engagement with health services in relation to his vascular disease. It is clear that professionals, as well as Z's family, regarded many of the decisions taken by him to not be in his interests. There is evidence of

[22] Stoke-on-Trent DHR 2/2014

professional persistence in attempting to persuade him of this. Professionals were however constrained from intervening because Z had the capacity to make such decisions.

21.4 The Stoke-on-Trent City Council Adult Safeguarding Team are working with other Adult Social Care teams to put in place alternative methods of engagement and intervention when adults have declined support via formal procedures[23] in order to address the safeguarding concerns. The Review Panel was informed that this is about making safeguarding personal and that the local 2016 Adult Safeguarding Procedures provide guidance on this for professionals.

21.5 Coercive control

21.6 The Review Panel recognised that the reluctance of Z to engage with agencies in connection with abuse by R was at least in part attributable to what would, in the context of an intimate or familial relationship, have constituted coercive and controlling behaviour[24]. The Panel considered whether there were approaches used by professionals supporting victims of domestic abuse which could be beneficially transferable to adult safeguarding services. It was identified that this was already taking place with coercive control and tactics to address its impact on the engagement of victims included in staff briefings and the online training provision offered by the SSASPB. The Review Panel was advised that higher level training, with specialist professional input, was being considered but had not to date been arranged.

21.7 The Review Panel recommended that:
The Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board should consider what further action is required to promote awareness of behaviour that may be coercive and controlling, in the context of adult safeguarding, and ensure that training in the skills to effectively respond to this is available to professionals.

21.8 Conclusion

21.9 Despite consistent denial by Z and there being insufficient evidence to prosecute R for assaulting him, there was a basis in May 2015 for professionals to have considered Z at risk from R.

21.10 With regard to the level of risk, both the seriousness of the incident leading to the Adult Safeguarding Investigation and a history of violence by R and Z involving weapons should have indicated that this was significant; although the only direct indication of murderous intent was not thought by Z's neighbour to reflect a genuine threat and accordingly not reported.

21.11 Practice in responding to the risks that R posed to Z should have been more joined up and in particular should have included joint face to face contact with Z. It cannot however be known whether this, or indeed any approach to understanding and addressing the reasons behind Z's non-engagement, would have overcome this barrier to providing effective preventative intervention.

[23] Under the Care Act 2014 Section 42.
[24] Serious Crime Act 2015, section 76.

RECOMMENDATIONS

21.12 The Review Panel made the following recommendations:

21.13 ***The Stoke-on-Trent Responsible Authorities Group should highlight to all partner agencies the learning from this review about the importance, when implementing significant organisational changes, of ensuring that robust arrangements are in place for maintaining continuity of care and other service provision, particularly to vulnerable individuals.***

21.14 ***The Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board should proactively raise awareness of the current local Adult Safeguarding Procedures and seek assurance from all partner agencies that relevant practitioners understand their responsibilities and are appropriately applying the procedures. This should specifically include reinforcement that:***

1) ***where it has been decided that a joint investigation is required the Social Worker, the Police Officer and all other professionals involved must clearly plan who is to undertake which aspects and conduct at least an initial joint visit; and***

2) ***where a single agency enquiry has been agreed, if there is concern around potential coercive control then arrangements must be made for a face to face meeting to take place. Such a meeting should be undertaken by two professionals.***

21.15 ***The Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board should consider what further action is required to promote awareness of behaviour that may be coercive and controlling, in the context of adult safeguarding, and ensure that training in the skills to effectively respond to this is available to professionals.***

21.16 Recommendations for action to improve their services were proposed by agencies that contributed to this Review. The Review Panel decided that the applicability of these was wider than individual organisations and that they should be encompassed within recommendations from the Review as a whole.

21.17 Implementation of the action plans will be monitored under arrangements agreed by the Stoke-on-Trent Responsible Authorities Group. The Responsible Authorities Group will also implement a communications plan which ensures that learning from the Review is effectively disseminated.

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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 lived together in Stoke-on-Trent. In June 2015 emergency services received a call from the alleged perpetrator who stated that he had found the victim dead in the bath at their home address. The perpetrator was arrested at the scene but released on Police bail whilst post mortem investigations were carried out. The post mortem later identified that the victim had died from

drowning but that there were numerous old and recent injuries. On the basis of the victim's injuries and other evidence gathered by the Police the perpetrator was charged with murder in April 2016 and remanded into custody.

3 Grounds for Commissioning a DHR:

3.1 A DHR Scoping Panel met on 11 May 2016 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.	
The alleged perpetrator is a member of the same household as the victim	**X**

3.2 The recommendation to commission this Review was endorsed by the Chair of the Stoke-on-Trent Responsible Authorities Group.

4 Scope of the DHR

4.1 The Review should consider in detail the period that commences from June 2012 (when the alleged perpetrator was released from prison and moved in with the victim). Summary information regarding significant events outside of this period would also be considered.

4.2 The focus of the DHR should be maintained on the following subjects:

Name	Z	R
Relationship	Victim	Perpetrator
Age (June 2015)	69	59
Date of Death	June 2015	N/A
Ethnicity	White British	White British
Address of Victim:	Stoke-on-Trent	

4.3 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.

4.4 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. These issues should be considered in the context of the general areas for consideration listed at Appendix 10 of the Guidance.

- Violence, abuse and neglect between two people in the same household who were not in an intimate relationship, and the effectiveness of support services

5.2 Individual Management Reviews are required from the following agencies:

- Staffordshire Police
- University Hospitals of North Midlands NHS Trust
- NHS England North Midlands (in respect of primary care services)
- Stoke-on-Trent City Council Adult Social Care
- West Midlands Ambulance Service

5.2.1 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.

5.3 Where an agency has had involvement with the victim and alleged perpetrator a single Individual Management Report should be produced.

5.4 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.

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

5.6 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.

5.7 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 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 Nathan Dawkins, Stoke-on-Trent City Council, who will facilitate this process. Interviews with staff should be conducted in accordance with the Guidance.

5.8 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 Nathan Dawkins, Stoke-on-Trent City Council.

5.9 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:

- National Probation Service
- North Staffordshire Combined Healthcare NHS Trust
- Arch North Staffordshire (In respect of domestic abuse of the alleged perpetrator's ex-wife)
- Staffordshire and Stoke-on-Trent Partnership NHS Trust
- Stoke-on-Trent City Council IDVA Service
- North Staffordshire Combined Healthcare NHS Trust
- Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership.

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 alleged perpetrator, during the scope of the Review; this should be notified immediately to Nathan Dawkins, 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
- University Hospitals of North Midlands NHS Trust
- NHS England North Midlands (in respect of primary care services)
- Stoke-on-Trent City Council Adult Social Care
- West Midlands Ambulance Service
- Arch North Staffordshire
- West Midlands Ambulance Service.

10 Communication

10.1 All communication between meetings will be in confirmed in writing and copied to Nathan Dawkins, 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 Nathan Dawkins, 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 families of the victim and the perpetrator will be advised that this review is being conducted.

12.2 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.

12.3 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 IMRs and Summary Reports should be submitted by 8 July 2016 with a view to the first Review Panel meeting being convened in late July/early August 2016.

14.2 The review should be aim to be completed and submitted to the Chair of the Responsible Authorities Group by November 2016.