West Cumbria Community Safety Partnership

Domestic Homicide Review in relation to Gerald

Date of homicide June 2020

Independent Chair and Author: Stuart Douglass

Report completed August 2022

Approved for publication October 2023

Preface

The Independent chair and review panel offer their deepest sympathy to the family, partner, and friends of Gerald.

This review is about considering the events prior to a homicide and whether agencies can learn from that to improve understanding and response in the future.

The chair would like to thank Gerald's partner, Sarah, and Paul, close friend of Gerald, for assisting the review in hearing Gerald's voice. They spoke of Gerald with great affection and warmth.

Further thanks are extended to DHR panel for their engagement and contributions and to the following in relation to the sharing of reports and statements to inform this review:

Detective Superintendent Dan St Quintin, Senior Investigating Officer, Cumbria Constabulary
Dr Stephen Barlow Consultant Forensic Psychiatrist
Dr Mark A Turner, Consultant Forensic Psychiatrist

1. Introduction

1.1 This report of a domestic homicide review (DHR) examines agency responses given to Gerald, a resident of Cumbria, prior to his death in June 2020.

1.2 Gerald was killed by his brother Mark.

1.3 The review considers agency contact and involvement with Gerald and his brother Mark during the 12 months prior to the homicide[1].

1.4 The rationale for the period chosen was that scoping of agency contact did not indicate any historical conflict issues between the brothers and Mark's mental health is understood to have deteriorated significantly in the period immediately preceding the homicide.

1.5 The purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change to reduce the risk of such tragedies happening in the future.

2. Timescales

2.1 Cumbria Constabulary referred the homicide for consideration for a DHR to West Cumberland Community Safety Partnership on 29th June 2020.

2.2 The referral was formally scoped in line with Home Office statutory guidance[2] on 29th July 2020 with a range of key agencies and organisations who may have had previous contact with the victim and perpetrator.

2.3 The Community Safety Partnership notified the Home Office of their intention to undertake a Domestic Homicide Review on 4th August 2020.

[1] Police and Probation held some historical records in relation to offending by the perpetrator and these are considered in the report despite being significantly outside the DHR time frame. In addition, agency chronologies from agencies covered the period between 2015 to 2020 to provide contextual information.

[2] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

2.4 The Domestic Homicide Review (DHR) was commissioned with due regard to the Domestic Violence, Crime and Victims Act 2004 and relevant criteria to this case are highlighted in bold. The Act states:

In this section "domestic homicide review" means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse, or neglect by—

***a 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.

2.5 The chair/author was appointed in August 2020 and initial review panel meeting commenced work on the DHR in September 2020. Following this initial meeting the chair unfortunately had to withdraw due to personal circumstances and a new chair commissioned. The review concluded in August 2022.

2.6 The criminal proceedings in relation to Mark concluded in December 2021. Mark had entered a guilty plea to Manslaughter on the ground that his mental state at the time of the killing was such that his responsibility for what otherwise would have been murder was diminished. The prosecution accepted that plea and he was sentenced to 21 years imprisonment.

2.7 The review took longer than the 6 months expected in the guidance. This was due to the criminal proceedings and the continuing impact of the COVID-19 pandemic. The chair agreed extension to Individual Management Review preparation for the Clinical Commissioning Group on behalf of the GP practice involved in the review. The panel requested further work on the GP Individual Management Review, report and this added further delay.

3. Confidentiality

3.1 The findings of each review are confidential until agreement to publish has been given by the Home Office Quality Assurance Panel.

3.2 Pseudonyms are used throughout the report to protect the identity of the individual(s) involved as follows.

Victim -	Gerald
Perpetrator -	Mark
Partner of victim -	Sarah
Friend of victim -	Paul

3.3 The Pseudonym of "Gerald" was chosen by his partner Sarah and the pseudonym of Sarah was also agreed with her. Paul declined an offer to choose a pseudonym and asked the chair to decide this on his behalf.

3.4 The victim was White British and aged 39 years at the time of the fatal incident.

3.5 The perpetrator was White British and aged 37 years at the time of the fatal incident.

4. Terms of Reference and Methodology

4.1 The Domestic Homicide Review followed the methodology outlined in the Home Office statutory guidance. Sources of information included:

- Individual Management Reviews – reports
- Information report – Police and Probation
- Medical reports prepared pre-trial – mental health of the perpetrator
- Interviews with the partner and friend of the victim
- interviews of staff
- a combined chronology
- documents and statements provided by the homicide investigation team, Cumbria Constabulary
- prosecution summary
- relevant literature review

4.2 The terms of reference were agreed following the initial Panel meeting on 01/03/2022 and are attached in full as appendix 1.

5. Involvement of family, friends, work colleagues, neighbours, and wider community

5.1 The chair initially contacted the parents of Gerald via the Victim Support Homicide Service who provided advocacy to the family, and they did not respond. Subsequently the chair made contact via the Probation Victim Contact Scheme, and they indicated that they did not feel able to engage in the review process.

5.2 Participation in DHRs is voluntary and for grieving families it is understandable that they may not feel able to assist a review.

5.3 Gerald's partner, Sarah, was contacted by the chair following an approach on his behalf made by Cumbria Constabulary Family Liaison Officer and Home Office DHR letter. Sarah contributed to the review and was given the opportunity to consider the terms of reference and the draft report and to discuss this with the chair. Sarah was offered advocacy support but declined this.

5.4 Sarah further assisted the review in contacting a close friend of Gerald, Paul, who also agreed to speak to the chair. The chair briefed Paul on the DHR process and offered advocacy support which Paul declined.

5.5 The police homicide investigation collected statements from a wide range of sources, and these were shared with the chair. They included accounts from family, friends and neighbours and gave some indication of background information on Gerald and his relationship with Mark.

6. Involvement of the perpetrator

6.1 The chair approached the perpetrator in writing, via his Offender Manager. The perpetrator did not respond. The Chair contacted the psychiatrists engaged in Mark's assessments pre-trial, and key reports were shared which gave insight in relation to the perpetrator in the period covered by this review.

7. Contributors to the Review

Cumbria Constabulary	Information report/investigation statements/Panel
Her Majesty's Prison and Probation Service	Information report/Panel

Cumbria County Council -	Information reports/Panel/specialist safeguarding advice
Department for Work and Pensions	Information report
Allerdale Borough Council – Council Tax Department	Information report
Riverside Housing	Information report
Dr Stephen Barlow – Consultant Forensic Psychiatrist	Information reports
Dr Mark A. Turner – Consultant Forensic Psychiatrist	Information report
Human Kind - Linzi Butterworth/Cat Wakelin	Briefing session and advice to panel on New Psychoactive Substances

7.1 Individual Management Review authors had no management responsibility for any staff who had contact with either Gerald or Mark.

8. Review Panel Members

8.1 Members of the Panel were as follows.

Cumbria Constabulary	Detective Inspector Suzanne Redikin Detective Constable Sarah Edgar DHR/SPR SPOC
Cumbria County Council	Sarah Joyce, Service Manager Safeguarding Adults
North West Ambulance Service	Sharon McQueen, Safeguarding Practitioner (Cumbria/Lancashire area)
Independent Chair/Author	Stuart Douglass
Her Majesty's Prison and Probation Service	Emily Kirkbride, Deputy Head of Probation Delivery Unit - Cumbria
North East North Cumbria Integrated Care Board	Molly Larkin, Safeguarding Designate Nurse, Adults and Children Looked After, Mental Capacity Act Designate and Court Protection.
Eden District Council	Clare Stratford – DHR Coordinator Cumbria
Independent Observer	Shona Priddey – (shadowing the chair)

North Cumbria Integrated Care NHS Foundation Trust	Sam Finn - Safeguarding Specialist Practitioner (Social Worker)
Human Kind	Linzi Butterworth, West Cumbria Team Leader
Allerdale District Council	Holly Cosgrove, Housing Options Manager
Cumbria Northumberland Tyne and Wear NHS Foundation Trust (CNTW)	Sheona Duffy, Acting Team Manager Safeguarding and Public Protection.
Victim Support[3]	Sarah Place, Senior Operations Manager

8.2 The panel met on 5 occasions. Panel members had no line management responsibility for any staff who may have contact with Gerald or Mark and the chair was satisfied that the panel members were independent. In addition, the chair had several individual discussions with panel representatives.

9. Author of the Overview Report

9.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews[4] sets out the requirements for review chairs and authors. In this review the chair and author roles were combined.

9.2 Stuart Douglass was appointed as the Domestic Homicide Review chair and author. Stuart is an independent practitioner with his previous career in safer communities and safeguarding senior management in local government for over 30 years. Stuart was seconded to the Local Government Association, as a senior policy officer in 2004 and was chair of the Associations Community Safety Advisers for over 10 years.

9.3 Throughout his career, Stuart has had responsibility for domestic abuse policy, commissioning and development within both local authority and partnership settings. Stuart led the team to establish the successful implementation of a domestic violence court in Sunderland and has undertaken a range of domestic abuse training programmes throughout

[3] Following the Home Office Quality Assurance feedback, it was recognised that panel had not secured advice from an Independent Domestic Abuse specialist. This was due to the large volume of DHR reports being carried out at that time and the circumstances of this case. The report has subsequently been reviewed by an independent specialist in Cumbria and comments reflected in the report.

[4] Statutory guidance for the conduct of Domestic Homicide Reviews, published December 2016, Home Office.

his career. Specifically, Stuart has experience of Domestic Homicide Reviews, Child Serious Case Reviews and Safeguarding Adult Reviews. Stuart completed approved DHR Chair training in 2016 following a 12-month period shadowing a DHR chair and he continues to develop his practice via the Action After Fatal Domestic Abuse DHR chairs network.

9.4 Stuart has not previously been employed by any agency engaged in this review.

10. Parallel Reviews

10.1 The criminal proceedings concluded in December 2021.

10.2 HM Senior Coroner for Cumbria has opened and adjourned an inquest. The chair updated the coroner on progress of the DHR throughout the process.

10.3 There were no other parallel reviews.

11. Equality and Diversity

11.1 The review gave due consideration to each of the protected characteristics under Section 149 of the Equality Act 2010.

11.2 The review panel identified disability as a protected characteristic relevant to this review. Gerald was registered blind with partial sight. Whilst accounts demonstrated that he had some independence, he did rely on family to assist him and for example would struggle to navigate when in unfamiliar areas in poor light conditions.

11.3 There were no other protected characteristics relevant to the review.

11.4 Of domestic homicide victims (killed by ex/partner or a family member in England and Wales) for the year ending March 2017 to the year ending March 2019 77% were female and 96% of suspects were male[5] .

11.5 Sibling homicides are relatively rare but typically demonstrate that they are commonly brother on brother (fratricide) rather than sister on sister (sorocide). Academic study in this area is limited, however Canadian research has indicated that fratricide comprises approximately 2% of all intra- familial homicides where analysis of national data on fratricide

[5] Office for National Statistics (ONS). Domestic abuse victim characteristics, England and Wales: year ending March 2020

show that adult males are considerably more likely to be offenders and victims of fratricide. A previous study suggested there were two main categories of fratricide: related to alcohol intoxication or associated with mental disorder.[6]

11.6 Gerald was killed by his brother during the COVID pandemic. In March 2020 there was widespread concern about the safety of vulnerable people potentially isolating with abusers but also the impacts on mental health of victims and perpetrators and abusive behaviours from perpetrators.

11.7 The National Police Chiefs Council and College of Policing working with the national policing Vulnerability Knowledge and Practice Programme (VKPP) produced a report of potential lessons based on domestic homicide and suicide following domestic abuse. During the COVID lockdown periods over 12 months there were 40 adult family homicides with an even split of male and female victims and 90% of perpetrators were male. In relation to fratricide (sibling murder) they reported 6 cases and all of them were brothers with no cases of sister-on-sister homicides. Whilst the number is relatively small from which to draw conclusions, they reported the cases typically demonstrated recorded drug or alcohol (mis)use either historically or just prior to the homicide.[7]

11.8 Specifically In terms of disability, the 2015 Crime Survey for England and Wales indicated that women and men with a longstanding illness or disability are more than twice as likely to experience domestic abuse than women or men with no longstanding illness or disability[8]. 8% of men with a long-term illness or disability had experienced domestic abuse compared to 3.2% of non-disabled men.

11.9 People with disabilities can be in vulnerable circumstances and physical disabilities may decrease their ability to physically defend themselves and escape from abuse[9].

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[6] Intrafamilial homicide: A descriptive study of fratricide in Quebec - D. Bourget, P. Gagné, A. Labelle

[7] Domestic Homicides and Suspected Victim Suicides During the Covid-19 Pandemic 2020-2021 - Lis Bates, Katharine Hoeger, Melanie-Jane Stoneman, and Angela Whitaker

[8]://safelives.org.uk/sites/default/files/resources/Disabled_Survivors_Too_Report.pdf

[9] https://www.anncrafttrust.org/resources/disability-domestic-abuse/

11.10 Disability can create isolation and lead to a smaller support network making it difficult for family and friends to recognise signs of abuse. Access to support and opportunity to disclose abuse to professionals may be limited further if abuse is perpetrated by a partner or carer who may be present at interactions with professionals.

11.11 Safe Lives in their 2017 report on disabled people and domestic abuse reported that in 2015-2016 0 out of 925 referrals of disabled victims to domestic abuse services were from adult safeguarding[10].

12. Dissemination

12.1 Recipients who will receive copies of the review report:

- Family representative
- Gerald's partner
- West Cumbria Community Safety Partnership
- Office of the Police and Crime Commissioner
- Domestic Abuse Partnership
- HM Senior Coroner Cumbria

13. Background Information (The Facts)

13.1 In June 2020 Mark attended the home of his brother Gerald and killed him with an axe and knife.

13.2 Mark was initially charged with murder, however prior to trial it was considered that he was experiencing delusions at the time of the homicide[11]. He entered a plea of guilty to manslaughter and was sentenced to 21 years in prison.

14. Background prior to the timescales under review.

14.1 Gerald was registered as blind and had been so since childhood.

[10] https://www.anncrafttrust.org/resources/disability-domestic-abuse/

[11] Forensic Psychiatry reports prepared for the defence and prosecution post homicide demonstrated some difference in opinion as to Mark's fitness to stand trial, however, both Dr Barlow and Dr Turner in a joint statement agreed that there was evidence to suggest that Mark, "was suffering from a psychotic illness involving delusions about his brother at the material time and, if he killed his brother, this would have been a significant causal factor in the killing".

14.2 The health information showed that Gerald had a cluster of serious health conditions; these included Thyrotoxicosis (September 2019), Transient Ischaemic Attack (September 2019), Cerebral Vascular Accident commonly known as a Stroke (September 2019) and Atrial Fibrillation (September 2019), which is an irregular heart beat which requires treatment to prevent adverse cardiac impact. He also received treatment for hypertension and closely linked Glaucoma commonly described as raised intraocular (eyes) pressure. In addition, Gerald was diagnosed with the life limiting condition of stage 4 Renal (kidney) disease. All the above conditions were overseen by specialists within the local hospital teams including Cardiology and Endocrinology. Gerald complied with treatments and no adverse flags related to behaviour, domestic abuse, substance and or alcohol misuse were recorded.

14.3 Gerald and Mark were brothers and were brought up by their parents in Cumbria. They were consistently described in a range of family and friend police statements as being very close from an early age and often socialising together throughout adulthood.

"Gerald and Mark are brothers and have always been inseparable when growing up. Given Gerald's disability Mark has always been very protective of Gerald and looked after him no matter what."

"Gerald has always been a very popular and likeable person. Gerald has always been the level headed and sensible one out of him and Mark. Gerald has always worked for a living and from my knowledge wasn't interested in drink or drugs. Gerald was born very prematurely and has always suffered with his eye sight. However, when growing up he had learned to the live with his disability. He became involved in sport at a young age in school and continued to keep fit as an adult. Gerald achieved the grades he needed in order to get a full-time job. Since becoming an adult, he has been independent and worked all his life. Gerald lived alone and was fully capable of looking after himself with some support from his mother. However, I am aware that Gerald has had a stroke recently which has affected how many hours he could do at work. I don't know the full details of how the stroke has affected him." - statement of Gerald's paternal aunt.

14.4 Gerald was described as well-known and popular in the local community and despite challenges of his disability he socialised regularly, liked to travel (alone or with friends), and routinely trained at local gyms.

14.5 Gerald's closest friend, Paul, spoke to the chair and described he had known Gerald for over 20 years after meeting socially via a member of his family who worked with Gerald. The friendship grew with Paul and his partner, and they often holidayed as a group with Gerald, sometimes 3 times per year and they had travelled to the Caribbean, Far East, Mexico, and Europe. On a holiday in Egypt, they had made friends with a group from Holland and subsequently travelled out to visit them. Gerald was described as not drinking alcohol much and very focussed on saving for holidays and buying his house in 2013.

14.6 Paul described Gerald as being incredibly strong at lifting weights, with the local gym buying in heavier weights for Gerald to train with, and whilst his eyesight prevented him from playing rugby, Gerald indicated that training was a sport he could participate in as well as a social outlet for him. Paul recounted that Gerald had said that he started gym training with Mark when they were about 17 and 15 years old.

14.7 Paul described how Gerald would try not to draw attention to his sight disability though stated that this was deteriorating especially after his stroke in 2019. When they went to the pub near Paul's house Gerald would hold his friend's arm, though he could manage to get to a local shop near his house on his own.

14.8 Gerald liked sport and supported a premiership club, occasionally travelling to matches with Mark and watching sports on TV with him.

14.9 The brothers had separate homes near their parents, on a 1930's housing estate on the outskirts of a large town, originally built to accommodate steelworkers and their families. Gerald lived independently in his own home and was supported by his mother and father with transport to work, shopping and some household tasks.

14.10 Gerald was described by his father as never losing his temper. He also indicated that the brothers watched sport at each other's houses but did not stay over.

14.11 Gerald was reportedly very careful about his home security. His parents and Mark had a key to access his house.

14.12 Gerald had worked for a local office of the Department for Food, Environment and Rural Affairs since leaving school. Gerald's friend and partner both stated that Gerald liked his job and that his employer was very supportive of adapting his work role and environment as his eyesight diminished.

14.13 At the time of his death Gerald had been in a relationship with Sarah, who lived in a nearby town, for three years. Due to the Covid pandemic they self-imposed limitations on close contact due to both having health vulnerabilities, however, stayed in extensive daily contact by phone and social media. They were planning holidays abroad.

14.14 Sarah described Gerald as extremely positive, “nothing ever troubled him”, and how he would strive to quickly overcome any challenges such as his recent stroke. She spoke daily to him throughout the COVID Pandemic when they were kept apart by COVID restrictions and guidelines. She described his sense of humour and how they never argued except over what she saw as Gerald’s “old fashioned” insistence to pay for meals and drinks when they were away or out socialising.

14.15 Sarah had not met Mark however was aware the brothers watched sport together and she indicated nothing suggested to her that Gerald was worried about anything or any conflict with his brother.

14.16 Gerald had no other person living with him at the time of the homicide.

14.17 Mark was aged 37 at the time of the homicide and had a child who lived with him.

14.18 Mark was unemployed at the time of the homicide however had previously worked at a local energy plant and service industries.

14.19 Mark lived in social housing and records indicated he had been in arrears with rent for some time though kept in communication with the social housing provider and was not facing any tenancy action.

14.20 Reports from police and probation recorded that Mark had three recorded incidents on record which included two domestic assaults on two separate partners, and an altercation within a public house. The dates for these are 2004, 2006 and 2008 and each incident and outcome are briefly summarised in the following paragraphs.

14.21 In 2004, a female (21 years old), called the police on the 999 system. She reported that Mark, her ex-partner was outside her address, he was threatening to break in and batter her. She reported that he was drunk at this time.

Police attended the scene and spoke to both parties. Mark stated he had turned up at the property to collect his belongings. Police observed a broken window at the property, and Mark was arrested and subsequently charged with Criminal Damage. Safeguarding measures were completed with the victim by police.

14.22 In 2006, police received a 999-call from a 19-year-old female. She reported her boyfriend had a knife and was coming up the stairs. She added he had already threatened to kill her. When probed for more information by the Control Room Call Handler she replied, "HE IS COMING QUICK" and then the line cleared.

14.23 Police attended the address where both the victim and Mark were present, a knife was recovered, and Mark was arrested.

14.24 A 10-point plan was completed with the victim[12]. When completing this the victim disclosed that Mark had returned home drunk that evening. He had grabbed her by the neck and windpipe, slapped her face and continued to grab at her windpipe causing reddening. She had further reddened skin and minor bruises. She also indicated that the relationship was over. This had been the first reported domestic incident and there had been no previous calls for service to this address.

14.25 An investigation plan included taking a statement from the victim and photographs of her injuries. Mark was interviewed and charged with the offence of Common Assault.

14.26 A Domestic Abuse Risk Assessment was conducted by an officer within Child and Adult Protection Unit based on the recorded 10-point plan. It was grade Bronze (standard). The risk was recorded as Extremely remote and the potential level of injury Major (Actual Bodily Harm, Threats, Harassment and Damage are within this category). The victim was subject of a follow up call to offer support and advice by the officer conducting the risk assessment.

14.27 The relationship ended, and the female victim moved back to live with her family in another county.

14.28 In respect of the offence Mark appeared at magistrates in 2006 and received a Suspended Sentence Order, 8 weeks custody, suspended for 12 months with a 200-hour Unpaid Work Requirement. This followed a trial in relation to an offence of Assault by Beating. The order terminated in 2007 on completion of the unpaid work. Probation records indicated that

[12] This was the recording mechanism used by police to record domestic incidents.

attendance was satisfactory, and no enforcement action was required in relation to completion of this order.

14.29 In 2008 police located a fight outside a Public House in the town centre. Two males and female were involved. The two males were arrested, and one was identified as Mark. The two males had been drunk, they were throwing punches at each other causing alarm and distress to other people.

14.30 Both males were charged with a public order offence of Threatening Words/Behaviour and Mark appeared at magistrate's court and received a 12-month Community Order with a 120-hour Unpaid Work Requirement. The order terminated in April 2009 on completion of the unpaid work. Attendance was satisfactory and no enforcement action was required in relation to completion of this order.

14.31 Mark reportedly worked for several years for a scaffolding company subcontracted at a nuclear power station between 2009 and 2017. Paul described that he understood this was seasonal, involved shift work and was sometimes based in decontamination areas on the site therefore there would be periods where he could not return to the job for example to take down the scaffolding for a 6-week period.

14.32 Mark liked to play sport and was involved in the local rugby club. Gerald took Paul to social events ran by the club and so he had known for Mark for around 10 years. Paul described the brothers extremely close to each other and their parents, who were described as loving both sons in equal measure.

14.33 Paul had not seen Mark for over 3 years at the time of the homicide and only had one conversation by telephone with him in that period, to confirm the ward Gerald was on after his stroke in 2019. Paul recounted that Gerald had said that Mark had become "secluded" and "locked himself away". Paul said there was never a "bad word" between the brothers and echoed all the other accounts of incredible disbelief in relation to the homicide.

14.34 Evidence post homicide indicated that Mark was a long-term user of cannabis and had transitioned from this to regular use of synthetic drugs.

15. Friend, employer, and wider community contributions

15.1 The Review chair was given access by Cumbria Constabulary to a range of statements collected during the homicide investigation from friends and neighbours who knew Gerald and Mark. These statements provided valuable insight.

15.2 Gerald's girlfriend Sarah and closest friend Paul were approached by the chair and assisted the review in giving Gerald's voice to the review.

16. Chronology of key events June 2019 to June 2020.

16.1 The DHR scoping had identified that Gerald had no contact with any agencies scoped or engaged in this review time frame other than health services in respect of his sight disability and other health related issues. Gerald had four contacts with his GP practice (for general health issues) between June 2019 and December 2019. There were no issues of note regarding any interaction with Gerald who was described by staff (interviewed as part of the GP Individual Management Review) as always presenting as positive and friendly in his interactions with staff.

16.2 **September 2019**: Gerald was admitted to hospital with a transient ischaemic attack[13] .

16.3 **December 2019**: Mark contacted his local Council to request backdating of his Council tax reduction stating that he has been late in applying due to mental health issues.

16.4 **January 2020**: Mark contacted his mother by social media messaging and refers to events she cannot understand. Similar messages continue sporadically in the months prior to the homicide and include various accusations involving family members, neighbours, and wider community.

16.5 **February 2020** - Mark attended his GP practice to see a nurse practitioner with facial swelling and headaches. Medical notes consider cluster headaches, and he was prescribed pizotifen and sumatriptan.

[13] A transient ischaemic attack (TIA) or "mini stroke" is caused by a temporary disruption in the blood supply to part of the brain. The disruption in blood supply results in a lack of oxygen to the brain. This can cause sudden symptoms similar to a stroke, such as speech and visual disturbance, and numbness or weakness in the face, arms and legs. But a TIA does not last as long as a stroke. The effects last a few minutes to a few hours and fully resolve within 24 hours. Source https://www.nhs.uk/conditions/transient-ischaemic-attack-tia/

16.5 **March 2020** - On 20th March the Prime Minister announced a UK-wide partial lockdown[14].

16.6 **May 2020** - On the 18th, Mark contacted the Primary Care Centre (service that provided the town's GP Practice on the day appointments) via telephone to request a sick note. During the telephone contact Mark spoke of a traumatic childhood event, advising that when he was seven, he was jailed because he attacked another child. Mark stated, "they died at first but then they got put on life support". Mark advised that his parents disengaged from psychiatric services so that he wouldn't be taken into care. The GP notes of the consultation stated, '*no documentation of any of this; I'm sure if it is the case the GP will remember something as unusual*'[15]. It was then recorded that Mark said his parents tried to brainwash him that everything that had happened had just been a nightmare. Mark advised that people who had been involved in the incident, came back to the area and everyone found out and he lost his friends and had to give up his job at Sellafield.

The treatment plan records short term medication and a referral to First Step[16] and the GP sent a task to Solway Health Services to request a sick note be completed (as they are unable to issue from the Primary Care Centre). The records show that Mark advised that he was not keen on medication, the GP recorded that they advised that it's reasonable not to want to take medication and nobody is going to insist but agreed to a small dose of mirtazapine to try to take the edge off anxiety and insomnia.

16.7 Mark's symptoms are recorded as including feelings of intermittent thoughts of suicide, intrusive thoughts and poor sleep. Mark also advised that he was angry, outbursts of temper and wanting to harm himself and others, so he has isolated himself for two years and doesn't talk to his parents. The record showed no evidence of drug or alcohol misuse or an electronic warning flag for concerns about violent behaviour or domestic abuse.

16.8 **May 2020** - Four days later a different GP from Mark's GP practice followed up with a telephone consultation to Mark to discuss a sick note. It was recorded that a First Step letter

[14] This was followed 3 days later by the introduction of The Health Protection (Coronavirus, Restrictions) (England) Regulations 2020 (SI 2020/350)

[15] There Review found no recorded evidence to indicate that this event had occurred and in later interviews with Forensic Psychiatrists Mark indicated that this and other delusional beliefs he expressed prior to the homicide were not true.

[16] First Step is part of Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust and provides free, talking therapies to adults (18+) in North Cumbria. First Step can help with a range of common mental health problems including mild to moderate depression, anxiety disorders (such as chronic worry, panic attacks, health anxiety and obsessions), mild bulimia, anger, or sleep problems).

had been received regarding the patient's failure to contact them. *"Patient reported mood was better and no further suicidal ideas". Mirtazapine script hadn't gone to chemist so sent electronically. He requested a sick note for 2 weeks which was posted. Reminded that he had 7 days to contact First Step re counselling to keep the referral active".*

16.9 **May 2020** – Mark messaged his mother, and she suggested that he needs help. His response to the suggestion is abusive.

16.10 **May 2020** – on the 30th the Government announce a relaxing of lockdown restrictions for people who have been "shielding" in their homes with those who lived alone able to meet one other person outside.

16.11 **June 2020** - GP records note that First Step have advised the GP that Mark had failed to contact them within the allotted time. Fourteen days after the previous GP contact, the GP tried to telephone Mark to discuss his mood and failure to engage with First Step and records, *"no answer and message left for patient to ring the surgery".*

16.12 **Early June 2020** - Close friends visited Gerald to talk to him in his garden (due to Covid restrictions). He is described as "*upbeat*", and they will socialise again when restrictions lift.

16.13 **Mid-June 2020** - Government announce that all non-essential retailers in England can reopen from Monday 15 June providing they followed safety guidelines. In the following days they announce that the 2.2 million people in England who have been shielding since the beginning of lockdown would no longer need to do so from 1 August. From 6 July they will be able to meet up outside with up to five other people and to form a "support bubble" with another household.

16.14 **June 2020** (approximately 5 days before the homicide is discovered) - Gerald's father went to Gerald's house to do some painting and gardening and in his account to the police described Gerald as, *"making plans for the future and happy go lucky"*.

16.15 **June 2020** (3 days before the homicide is discovered)– a friend and former employer of Mark's (who hasn't had any contact with him for 5 years) is messaged by Mark with what he describes as "bizarre messages" and events.

16.16 **June 2020** (3 days before the homicide is discovered) Gerald and Paul message each other about football.

16.17 **June 2020** (2 or 3 days before the homicide is discovered) - Mark's mother visited him at his house. In her statement to police, she recounted that she mentioned trying to sort Gerald's passport out for his holiday. Mark asked who Gerald is going to Greece with. His mother responded, saying that he indicated "friends", but that it was probably Sarah. Mark said he thought that the relationship was over. As his mother went to leave, Mark ran after her and said, "he's (Gerald) going to do a runner to Thailand. I knew this meant one of his moods was coming on, so I left. A few weeks before he told his dad that he hadn't seen me for 10 years which was not true. When I look back, he would increasingly flip from aggression to normality". - extract from statement given to police by Gerald's mother.

16.18 **June 2020** (2 or 3 days prior to the homicide being discovered) – Gerald's neighbour said hello to him as she left the house for an errand and later heard him singing and playing music in his house.

16.19 **June 2020** – (approximately 2/3 days before the homicide is discovered) – Sarah visits Gerald to hand food and a gift of cakes. She leaves them behind the gate, and they talk socially distanced.

16.20 **June 2020** (2 days prior to the homicide being discovered) – Mark contacts a cousin (they rarely had contact) via social media. The cousin described Mark as sounding either "*drunk or on drugs, possibly both*". The conversation is described as "*not making sense. He was saying things and not elaborating on them*". The cousin describes Mark making bizarre allegations that made "no sense". The call ends with Mark saying, "*Don't worry I'm gonna go up there tonight and kill him*".

16.21 Two days later Gerald's mother discovered him deceased at his home.

17. Overview of information known

17.1 Gerald and Mark had been close throughout their lives, though Gerald did report that the contact had diminished slightly in recent years and from March 2020 Gerald was self-isolating due to COVID and his health vulnerabilities.

17.2 There was no evidence of any previous conflict between the two brothers and to the contrary numerous accounts evidenced that Mark had "looked out" for his brother both when growing up or when they were together in adult life.

17.3 Mark's historical police and probation records demonstrate a propensity for violent behaviour, and he had previous police contact on 3 occasions between the age of 21 and 25 years, resulting in 2 convictions related to violence and domestic abuse offences. These contacts were prior to 2008 and Mark does not come to police attention again until Gerald's homicide 12 years later.

17.4 Mark had worked at a local power plant for a subcontractor though after that job ended, he only worked sporadically after that time.

17.5 Despite having health difficulties, being partially sighted since childhood, and having a stroke in 2019, Gerald overcame these, and had worked full time since leaving school, bought his own home and led a full life socialising, travelling and regularly visiting the gym.

17.6 Gerald had been in a relationship with Sarah for almost three years. She spoke warmly of his thoughtfulness, kindness, and sense of humour. Sarah did not know Mark. She indicated that Gerald did not express any concerns about his brother nor exhibit any reason to be fearful or threatened by him or anyone other person in the period prior to the homicide.

17.7 There is evidence that Mark's drug use transitioned from cannabis use to smoking of "plant food" or "spice", an illegal synthetic cannabinoid.

17.8 In May Mark telephoned his GP to request a sick note but disclosed that he had almost killed another child when he was a child and was imprisoned for it. He reported that he had locked himself away for the last 2 years as he was suicidal, aggressive and wishes to harm others. The GP prescribes mild sedatives and refers Mark to a talking therapy service which he does not access. The GP checks records and can find no evidence of Mark's story. The GP is unaware from records that Mark is the carer of his child though records indicate that a female lives at his home. A follow up call by another GP indicates he is improving but a third and final subsequent contact is not responded to by Mark or followed up by the surgery. Mark is not seen face to face by any medical practitioner in these contacts.

17.9 During the period December 2019 to June 2020, post homicide accounts from family and friends reviewed by Forensic Psychiatrists indicate Mark was paranoid and delusional[17] in certain aspects regarding his family and brother and wider community.

[17] A delusion is where a person has an unshakeable belief in something untrue. https://www.nhs.uk/mental-health/conditions/psychosis/symptoms/

18. Analysis

18.1 The terms of reference and specific requests for the agencies providing Individual Management Reviews and chronologies were fully addressed. Summary of the conclusions to the terms of reference key lines of enquiry are considered in section 20 - Conclusions.

18.2 Fratricide is the murder of one's brother. It is rare but more common than sorocide, the killing of sister by sister. Non gender specific sibling homicide is now more commonly referred to as "siblicide". Research is limited in this area compared with homicide and domestic homicide more generally and tends to be US and Canada based rather than UK specific.

18.3 In a large-scale study by Bourget and Gagne[18] 2006, it was reported that around 505 of siblicides in the United States in 1988 involved alcohol. In Canada, the national data for siblicides indicates that 73% of offenders who killed their sibling were under the influence of either drugs or alcohol.

18.4 The authors published a further study in 2017 using a sample of 28 coroners' cases from a sample of 1000 domestic homicides and indicated that fratricide comprises approximately 2% of all intra-familial homicides. Analyses of national data on fratricide show that adult males are considerably more likely to be offenders and victims or fratricide. Most victims were stabbed to death. The murders usually occurred at the residence of the victim. In total, 39% of offenders suffered from a major mental illness and 21% were acutely intoxicated at the time. The authors conclude,

"Our data indicates that fratricides are most often impulsive and lack preparation. The most common method was the opportunistic use of a knife, suggestive of impulsive killing, and this is consistent with the rest of the information including the high rate of alcohol use and intoxication at the time. The study confirmed two main categories of fratricide: impulsive killing in the context of alcohol and dispute and killing associated with psychosis." [19]

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[18] Fratricide: A Forensic Psychiatric Perspective - Dominique Bourget, MD, and Pierre Gagne´, MD. J Am Acad Psychiatry Law 34:529–33, 2006

[19] Intrafamilial Homicide: A Descriptive Study of Fratricide in Quebec
D. Bourget, P. Gagné, A. Labelle
Journal: European Psychiatry / Volume 41 / Issue S1 / April 2017
Published online by Cambridge University Press: 23 March 2020, p. S151

18.5 Other authors cite reasons for sibling homicide regarding motives such as jealousy, resources, or competition over parental investment[20]. There was no evidence in this review that these reasons played any part in Gerald's homicide by his brother. There was an account that both brothers were supported and loved equally by their parents.

18.6 Following the homicide Mark's interviews with psychiatric services indicated that he had been a smoker of "spice", a New Psychoactive Substance (NPS) or chemical based drug designed to mimic traditional drugs such as cannabis or amphetamine (though may contain greater amounts of active components than found in traditional drugs such as cannabis).

18.7 Dr Barlow, in his assessment report of November 2020, interviewed Mark and indicated the following,

"He became acquainted with a local man who introduced him to "spice" (a novel psychoactive substance/synthetic cannabinoid). This man would visit him at home during the day, while his child was out of school and together, they would smoke cannabis laced with spice. He said he did this every day for around two years up until the alleged offence.

At first, he experienced mild sedation from using this drug, but gradually he began to notice some adverse effects, such as insomnia, breathlessness, and palpitations. After this he noticed problems with his memory. He began to "remember things that hadn't necessarily happened". For example, he would have memories of speaking to people, but other people would later tell him that these conversations had not taken place. He said that he began to wonder whether people were lying to him."

18.8 The DHR panel sought expert advice in relation to substance misuse from Humankind, the substance misuse service provider in Cumbria and were given a presentation in relation to the local impact of NPS.

18.9 Between 2016 and 2020 it was reported that availability had been widespread across some communities in Cumbria despite a legal ban in 2016[21] and the service had evidenced abuse

[20] https://www.psychologytoday.com/gb/blog/the-human-beast/202104/why-sibling-conflict-can-turn-deadly

[21] Psychoactive Substances Act 2016 restricted the open retail of psychoactive substances by banning the sale, supply, and importation of these drugs.

of "plant food"[22] with heroin using clients reporting injecting NPS rather than the more common use of smoking the substances. They described that unlike heroin, where users would typically engage with the service, it was found that NPS users did not want to do so.

18.10 There was a reported increase in psychiatric admissions of users demonstrating symptoms of psychosis and violent behaviours. Several deaths and amputations of limbs caused by health complications amongst those injecting was recorded. The service could not test at that time (due to the huge variations of compounds in NPS drugs testing continues to be challenging in the UK) though described close working with police and other agencies to tackle the issue. Although the problem seemed to subside prior to and during COVID it was believed that "plant food" had been manufactured and sold in the West Cumbria area throughout the pandemic. The mental health trust reported to panel that there were indications that the problem was returning post pandemic though was not yet at pre pandemic levels.

18.11 Relatively little is known about NPS though the effects relating to psychosis and violence have been acknowledged as having a major impact in UK prisons[23]. The verdict on whether NPS can cause mental illness continues to be debated though it is widely acknowledged that pre-existing mental health conditions can be exacerbated via use.

18.12 Doctor Barlow in his assessments of Mark summarises as follows,

"Based on his account, which is supported by evidence from various sources in the witness statements, I think that Mark was suffering from a severe and persistent paranoid psychosis at the time of the killing of his brother. This appears to have developed as a consequence of prolonged and frequent use of cannabis laced with synthetic cannabinoids. The key symptoms he describes are delusional memories (false recollections that the subject firmly believes to have happened)"

"On balance, I would support a partial defence based on "diminished responsibility" in this case. In short Mark was suffering a recognised medical condition at the material time (paranoid psychosis), resulting in an abnormality of mental functioning (delusions) that

[22] Mephedrone (also known as M-cat, Meow-meow, Plant Food) is a stimulant from a family of drugs related to amphetamines (such as speed and ecstasy). It can come in the form of powder, tablets, and capsules. It was made illegal in the UK in 2010 and had been widely available on the internet and often marketed as "plant food" hence the use of the name amongst users.

[23] HM Chief Inspector of Prisons for England and Wales Annual Report 2014–15

impaired his ability to form a rational judgement, and that this was a "significant contributory factor" in the killing".

"It would appear that Mark's psychotic illness has gradually improved over time without medical treatment. This is not unknown, particularly when the underlying cause of a psychotic mental illness is persistent substance misuse and this the ceases. Whilst drug-induced psychoses are usually relatively short-lived (lasting weeks or months), we are, as yet, still to understand the long-term effects of prolonged NPS use."

18.13 A UK study of inter family violence DHRs where a family member commits homicide of another family member looked at sample of 66 published DHRs and found that 53% of perpetrators had a diagnosed mental disorder of psychosis or mood disorders with undiagnosed disorders taking the figure to almost 80%. Substance misuse by perpetrators featured in two thirds of the homicides studied[24].

18.14 The only agency with a significant window into Mark's deteriorating mental health and associated risks were GPs following his telephone call in May 2020, around a month prior to the homicide. Mark rang the GP for a sick note but disclosed his mental health concerns (though not his substance misuse) and indicated he wished to self-harm and harm others. The GP recorded his account of how in childhood he recounted that he had almost killed another child, and whilst following the call the GP demonstrated diligence in checking historical medical records which showed no evidence of this, in hindsight, we know it to be an example of the delusional statements that were being made by Mark to family and friends (some of whom he had little contact with in recent years) in the period directly preceding the homicide. There was no record that the GP explored drug or alcohol use.

18.15 The panel considered that this was potentially a missed opportunity to refer to the specialist crisis mental health team to carry out a more immediate assessment rather than a referral to a counselling service. The follow up call 4 days later by a different GP from his surgery confirms his suicidal ideation and feelings have abated, however, again misses an opportunity to demonstrate professional curiosity[25] around the issues of self-harm and

[24] Bracewell, K. and Jones, C. Haines-Delmont, A. Craig, E. Duxbury, J. Chantler, K. (2021) Beyond intimate partner relationships: utilising domestic homicide reviews to prevent adult family domestic homicide, Journal of Gender-Based Violence, vol XX, no XX, 1–16,

[25] Professional curiosity is about having the capacity and communication skills to explore and understand what is happening with an individual or family. It is about asking more and using proactive questioning and challenge. It is about understanding your own responsibility

desire to harm others. The GP practice initially declined to give a view as to whether alternative referral may have been available or appropriate however upon re reviewing their IMR report they agreed that the referral should have been to the crisis mental health team rather than a counselling service based on the safeguarding concerns the interaction raised.

18.16 Review of the written referral to the counselling service First Step confirmed that the referral was inappropriate. In its heading sections on the referral form it states several exclusions including, "*that the service is inappropriate for "individuals presenting with high risk (e.g., plan or intent for suicide, presents a danger to others) or requiring an MDT mental health team approach*".

18.17 Both GPs reported they were unaware of Mark's family circumstances and that he was sole carer of his child (also registered at the same practice) and were therefore unable to explore safeguarding of those who may have been at risk from Mark's stated desire to commit harm. Panel were informed that genograms of family makeup are not routinely kept on patient medical records and this omission is considered in the review recommendations. The surgery confirmed that Mark's records did record that another person lived with him but that this did not indicate who that was or that it was a child in his care. Mark's disclosures may have benefited from further "professional curiosity" and questions about his wider circumstances to better identify potential risk i.e., "who did he live with" and "who might he wish to harm". There was no record of exploration by the GPs of drug or alcohol use.

18.18 In interview as part of this review, the former GP who took the initial call reflected that in hindsight that asking Mark to come to the practice to see a GP face to face before issuing his requested sick note may have been an option, though it must be remembered that the first COVID lockdown period was in place and many agencies were not working face to face to protect vital staff as part of the response to the pandemic risks (as they were understood at the time).

18.19 The practice follows up with a call four days later when Mark indicated his intrusive thoughts have subsided but following that become aware that Mark has not contacted First Step and rang him again 14 days later, Mark did not respond, and a message was left for him to

and knowing when to act, rather than making assumptions. It is about being interested in the person and the situation; not taking things at face value - asking 'why'? – source Norfolk Safeguarding Adults Board

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recontact the surgery. There was no further follow up or attempt to contact which represents a potential missed opportunity to seek further information and see how Mark's mental health concerns are progressing.

18.20 The former GP spoke to this review voluntarily and demonstrated reflection on the circumstances and practice context at that time. The medical practice responsible for Mark's local medical care (which has subsequently been merged with 5 practices who completed an Individual Management Review) have identified a number of actions to improve outcomes for future patients in similar circumstances[26].

18.21 Covid brought many challenges to primary care including avoiding face to face meetings for infection control purposes. In February 2020 just prior to Covid there were 3.3 million telephone appointments in England but by May 2020 this had risen to 7.8 million appointments. Conversely face to face appointments in February 2020 were 19.2 million but by May 2020 when Mark had GP contact, they had fallen to 7.7 million[27].

18.22 A study by the LSE and the Metropolitan Police indicated that there was a 17.1% increase in abuse from family members[28]. A study by the Mental Health Foundation found that differences in peoples responses to the pandemic were affected by their social and economic position in society and that those with socioeconomic inequalities were more likely to experience anxiety, panic, hopelessness, and loneliness. The study indicated that at the end of June 2020, "one in ten people in the UK reported having had suicidal thoughts or feelings in the past two weeks, and in certain disadvantaged groups there are even higher proportions of people with suicidal thoughts and feelings"[29]. Mark disclosed his suicidal feelings to the GP in May 2020.

[26] The GP Practice had undergone significant change following Covid which resulted in a number of smaller practices coming together as one large practice and the two GPs who had provided telephone consultations no longer worked at the Practice during the time period of that the DHR was undertaken. The first GP consultation was undertaken by a GP who had no previous contact with Mark prior to the telephone consultation during Covid. The follow up contact was completed by a Locum GP.

[27] https://www.health.org.uk/news-and-comment/charts-and-infographics/how-has-the-covid-19-pandemic-impacted-primary-care

[28] The Role of Exposure in Domestic Abuse Victimization: Evidence from the COVID-19 Lockdown - https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3686873

[29] Coronavirus: The divergence of mental health experiences during the pandemic – https://www.mentalhealth.org.uk/our-work/research/coronavirus-divergence-mental-health-experiences-during-pandemic

18.23 Throughout the pandemic, there were concerns that safeguarding issues were not identified and reported. This was often due to reduced 'face-to-face' contact between adults with care and support needs and professionals, families, and friends. Mark had isolated himself and had limited contact with family, was using psychoactive substances and was increasingly delusional. The GP at this time did not use the option of a face-to-face meeting with Mark despite that being open to them at that time in exceptional circumstances.

18.24 Mark had asked a relative to call him in the days before the homicide and whilst he was described as sounding "normal" though possibly under the influence of alcohol or drugs, the relative described that the short call was "strange", with Mark referring to historical events he believed had occurred (which his relative knew could not be true). The call ended with Mark indicating that he was going to kill his brother. The relative who had minimal contact with Mark did not believe that Mark would harm his brother as he did not sound angry and was at his own home so did not alert Gerald's family. The consistency of accounts of the close relationship of the brothers and Mark as a protective factor to Gerald together with the description and knowledge that Mark used drugs potentially led to seriousness of intent Marks statement being dismissed. Concerns could have been raised via a Safeguarding Adult alert, details of which are on the Cumbria Safeguarding Adults website (though response is not usually immediate) or a call to police or out of hours mental health crisis teams. Public awareness of this is possibly low and equally professionals demonstrated an incorrect referral regarding earlier disclosure of wanting to harm others or self by referring to a talking therapy service rather than a more immediate crisis mental health intervention.

18.25 In domestic abuse identification we increasingly look at the opportunities afforded by informed community bystanders to report to agencies who may be able to intervene or where they can gain advice on concerns they may have. Pilot programmes in the US and UK have been evaluated as positive on University Campuses, however, the participants require training and confidence to intervene and report abusive concerns[30].

18.26 Whilst not a specific recommendation of this review agencies should consider information on reporting and advice access for bystanders in their communications.

[30] Public Health England, April 2016 - A review of evidence for bystander intervention to prevent sexual and domestic violence in universities.

18.27 Mark had a previous history of violence including 2 domestic violence incidents. One of these involved what we now understand to be significant risk markers i.e., use of weapons. threats to harm/kill, victim fear, strangulation, assault, and separation. Laura Richards of Paladin Stalking Services states that, "Abusers who choose to strangle/choke victims are 70% more likely to go on to commit a homicide regardless of whether it is a Domestic Homicide or stranger murder"[31]

19. Conclusions

19.1 This report describes and analyses the events which led up to the fatal incident and the panel were able to establish an understanding of agency involvement with Gerald and Mark in the 12 months prior to the homicide. (Terms of reference - key lines of enquiry 1 and 2)

19.2 Gerald had physical health needs associated with his disability (and related conditions) and the review evidence indicated that health services in relation to this were responsive and accessible. (Terms of reference - key line of enquiry 3)

19.3 The review also evidenced that services were responsive and accessible to Mark, and he spoke directly to a locum GP when he contacted them by telephone in May 2020. (Terms of reference – key line of enquiry 4)

19.4 There was no evidence that service responses to Gerald were affected by the COVID 19 Pandemic, though Mark (when he contacted his GP asking for a sick note), was dealt with by two telephone consultations and a third (unsuccessful) telephone follow up, rather than be invited in to see the GP. The GP surgery were limiting face to face contact with patients at that time in line with national guidance, though the review understands that exception to this could be made if a GP considered this necessary. (Terms of reference – key line of enquiry 5 and 6).

19.5 Information regarding Mark's disclosure to the GP of wishing to self-harm and hurt others led to a referral to a talking therapy provider. There was no evidence of consideration of the potential harm to others or safeguarding consideration of his immediate family (the GP records had no genogram of family makeup). The initial GP in their contact with Mark refers him to a counselling service rather than considers a referral to a more immediate

[31] Reference Laura Richards Paladin Stalking services CEO & DASH & stalking risk assessment co-creator.

community based mental health crisis intervention team[32]. The three GP contacts over a nine-day period, one month prior to the homicide, did not evidence a degree of professional curiosity that the concerns reflect, and this was a significant missed opportunity to implement safeguarding for Mark and understand more fully his circumstances. (Terms of reference – key lines of enquiry 7/8)

19.6 High levels of consistency in accounts of the brother's relationship from family, close friends and Gerald's partner showed that there was no evidence or information which may have indicated that there was coercive or controlling behaviour, abuse, or violence in the relationship between the brothers prior to the homicide. (Terms of reference - key line of enquiry 8). There were likewise no accounts of violence to other family members, though whilst "delusional", Mark had been abusive to his mother via phone messaging in the period leading up to the homicide.

19.7 Mark had a history of violent offending including domestic abuse perpetrated to two former partners. In 2006 he is recorded as assaulting his partner by holding her by the neck. Non-fatal strangulation has been recognised as a key indicator of potential future homicide risk in relation to intimate partner violence and in 2022 a specific offence[33] was introduced in respect of this. The relevance of that in relation to the homicide of Gerald is that Mark has an evidenced propensity for serious assault.

19.8 It is of note that the three violent incidents previously described in this report occurred twelve years prior to the homicide and there were no police or other agency accounts of violent behaviour in the period following that until the homicide. Nonetheless, regardless of when previous abuse or violence is used, there is an on-going risk of continued violent and/or domestic abusive behaviour without intervention or an individual's motivation to change.

[32] Upon reviewing this version of the report, the Named GP for Safeguarding did raise that in order to refer to the Crisis Team he would need to obtain consent; there is no evidence that Mark was asked. However, the practice did think it was unlikely that he would have consented given that he didn't want the medication. The option left at that stage would have been to contact the police if there was a view that the situation placed self or others in a position of high risk / harm.

[33] The Domestic Abuse Act 2021 amends the Serious Crime Act 2015, introducing 2 new sections — section 75A and 75B— which will create a new and specific criminal offence of non-fatal strangulation and suffocation. – source Ministry of Justice

19.9 Mark was a single parent bringing up a child and no concerns regarding his parenting were evidenced. The child was however invisible to the GP who Mark contacted in May 2020. In addition, his child was not attending school at this time due to Covid restrictions again limiting opportunities for concerns to be identified. Given the concerns raised by Mark at this time further questions should have been raised to understand his home and family circumstances which if the caring for a child was known should have led to a wider "think family approach to understand and potentially ensure safeguarding of Mark and his child. The referral by the GP to therapeutic counselling was returned due to Marks referral being deemed inappropriate. Follow up via telephone with Mark by the GP practice after this recorded that Mark reported "feeling better". A further follow up call was not responded to or pursued further by the GP practice.

19.10 Mark was a user of cannabis and he indicated post homicide that this had developed into use of synthetic based drugs, known as NPS, which have risks associated with impact on mental health including psychosis and extreme violent behaviours. Research shows that exposure to parental mental health issues, substance misuse and domestic abuse are particularly harmful for children and young people. It is essential therefore that professionals who have contact with adults who have mental health difficulties, misuse substances, or are the victim or perpetrator of domestic abuse actively consider the impact on any children and adults being cared for and make safeguarding referrals where appropriate.

19.11 Evidence from family and friends indicated that Mark had been suffering a decline in his mental health for some months prior to him disclosing to his GP in May 2020 but there were no accounts that indicated that he had previously accessed support. By his own description Mark had withdrawn from social circles for the previous 2 years (Terms of reference – key line of enquiry 9).

20. Lessons to be Learnt

20.1 **New Psychoactive Substances** are a relatively recent phenomenon, and the drugs and their harms can rapidly change. The evidence of the impact on some users in terms of violence and psychosis is stark and requires continued effort from agencies in prevention and responding to the issue. Agencies have reported that the prevalence of NPS use may be re-emerging and will place potential risk of violence in relationships with partners, families, professionals, and the wider community. Disruption of County Lines and more traditional

drug markets of heroin, cocaine and cannabis may lead to users falling back onto NPS use which due to its complex nature we may be less experienced at in terms of both understanding the issue and tackling it and offering support. The COVID lockdown disrupted traditional drug supply from outside the UK in 2020. Agencies need their professionals to be aware of these risks.

20.2 In December 2021 the Government launched its 10-year strategy to tackle the harms associated with drugs[34]. The strategy was followed with guidance for delivery published in June 2022[35] and the creation of new Combatting Drugs Partnerships.

20.3 The strategy requires partnership at local level and throughout 2022 there are milestones for completion in relation to a needs assessment and key steps towards local delivery.

20.4 In Cumbria the Combatting Drugs Partnership is being developed and its links to Safer Cumbria Partnership are under discussion. The needs assessment must be completed by November 2022 and should assist in bringing together intelligence and focus in relation to the availability and impact of NPS in Cumbria and a recommendation is made in this regard (recommendation 1). It is of note that the guidance refers specifically to the consideration within assessments of, "specific case reviews in areas such as domestic homicide, offensive weapons homicide, mental health, and child and adult safeguarding". Given this and the timetable for development of the strategy locally, the chair shared a draft of this report with the senior Public Health lead for Cumbria to ensure that this DHR informed that process.

20.5 **Safeguarding** - disclosure of safeguarding concerns relating to an expressed wish to harm others need to be explored fully with risks to community, family and children assessed. Where possible agency records should assist in that process and whilst understanding that information may not be held on family makeup on health records it should be considered in assessment or if known recorded on the patient record. The report makes 2 recommendations in this regard (recommendations 2 and 3).

20.6 **Inter family abuse and homicide** - domestic homicides in an inter-family context may be less prevalent than homicides of intimate partners or former intimate partners, but nonetheless, should both feature within training and development for professionals. This is particularly

[34] https://www.gov.uk/government/publications/from-harm-to-hope-a-10-year-drugs-plan-to-cut-crime-and-save-lives

[35] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1083170/Guidance_for_local_delivery_partners_FINAL.pdf

relevant in respect of the recent statutory definition of domestic abuse as defined in the 2021 Domestic Abuse Act.[36]

'Abusive behaviour' is defined in the act as any of the following:

- physical or sexual abuse
- violent or threatening behaviour
- controlling or coercive behaviour
- economic abuse
- psychological, emotional, or other abuse

20.7 For the definition to apply, both parties must be aged 16 or over and 'personally connected' which is defined in the Act as parties who:

- are married to each other
- are civil partners of each other
- have agreed to marry one another (whether or not the agreement has been terminated)
- have entered into a civil partnership agreement (whether or not the agreement has been terminated)
- are or have been in an intimate personal relationship with each other
- have, or there has been a time when they each have had, a parental relationship in relation to the same child
- are relatives

20.8 With regard to the training and policy context, it is important to reflect this range of possible relationships between victim and perpetrator. The Review therefore makes a recommendation to ensure that local agencies provide assurance that abusive behaviour between relatives is given consideration in training and procedures (recommendation 4).

20.9 Additional single agency learning was identified during this review process via the CCG/GP internal agency review and those recommendations are in the process of being implemented. They are shown in the single agency action plan at section 22.

[36] The Domestic Abuse Act 2021 received royal assent on 29 April 2021

21. Review Recommendations. (action plan at appendix 2)

Recommendation 1
Safer Cumbria (Combatting Drugs Partnership) to ensure that the 2022 drug needs assessment considers the profile of New Psychoactive Substances to assist in informing the design of local strategies to support the reduction of serious violence and associated harms.

Recommendation 2
That when risk of harm to others is indicated by patients to health practitioners, assessment of who may be at risk should be routinely considered.

Recommendation 3
That where it is possible to do so, health agencies should consider whether records can indicate key family information and as a minimum childcare responsibility.

Recommendation 4
West Cumbria Community Safety Partnership to ensure that domestic abuse training reflect inter family violence as well as intimate partner violence.

22. Single Agency Recommendations (action plan attached as Appendix 3)

1. Primary Care Practice IMR - The Practice has identified that additional Domestic Abuse training would be beneficial to ensure that staff are fully aware of the current legislative definition of Domestic Abuse and that this is understood.

2. Although the profile of any open DHRs and the response timescales was included as a risk when an organisation was changing its structure or leadership (post the homicide the surgery was reorganised with 4 other practices into one practice. The practice reported that unfortunately, the correspondence pertaining to the request for an IMR was received by the generic inbox for Solway Health Services leading to lengthy delay in allocation of IMR responsibility. To prevent this in future they have now identified a new point of contact and provided this to the CCG Safeguarding Team to ensure DHR requests are dealt with in a timely appropriate manner.

1. Domestic Abuse training for Clinical and Administrative staff will be provided.

2. Domestic Homicide Review process awareness will be provided for Lead members of the Practice by 31/07/2022.

3. A Single Point of Contact should be established in every case which meets the statutory Review threshold within each Primary Care Practice and raised as a risk during organisational change.

4. All clinicians to be advised to ensure consistency in using clinical templates and system prompts. The practice will request that prompts contain reference to drug and alcohol misuse.

5. Learning from the DHR to be shared within the practice incident and clinical meetings.

6. All clinicians to be advised to seek guidance from the new practice Safeguarding Adult and Safeguarding Children Lead GPs.

Appendix 1 Terms of reference

The Review will work to the following Terms of Reference:

1) Domestic Homicide Reviews (DHR) place a statutory responsibility on organisations to share information. Information shared for the purpose of the DHR will remain confidential to the panel until the panel agree what information is shared in the final report when published.

2) To explore the potential learning from this domestic homicide and not to seek to apportion blame to individuals or agencies.

3) To review the involvement of each individual agency, statutory and non- statutory, with Gerald and Mark.

4) Stuart Douglass has been appointed as the Independent Chair and Author for this review.

5) Members of the Panel are as follows.
   a) Allerdale District Council
   b) Cumbria Constabulary
   c) Cumbria County Council
   d) Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
   e) Eden District Council (Cumbria DHR Coordinator)
   f) Her Majesty's Prison and Probation Service
   g) Humankind (Substance Misuse Provider)
   h) Independent Chair/Author
   i) Lancashire and South Cumbria Care Foundation Trust
   j) NHS North Cumbria Clinical Commissioning Group (as of July 1st, 2022, North East North Cumbria Integrated Care Board)
   j) North Cumbria Integrated Care NHS Foundation Trust
   k) North West Ambulance Service

6) The Panel to consider where necessary any specialist advice to support the Review.

7) For each contributing agency to provide a chronology of their involvement with Gerald and Mark during the relevant period.

8) For each contributing agency to search all their records outside the identified time periods to ensure no relevant information was omitted and secure all relevant records.

9) For each contributing agency to provide an Individual Management Review: identifying the facts of their involvement with Gerald and Mark, critically analysing the service they provided in line with the specific terms of reference; identifying any recommendations for practice or policy in relation to their agency.

10) To critically analyse the incident and the agencies' responses to the subjects, this review should specifically consider the following points:

- To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to identify and respond to disclosures of domestic abuse.

- To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result.
- To improve inter-agency working and better safeguard adults experiencing domestic abuse.

11) Agencies that have had no contact should attempt to develop an understanding of why this is the case and whether there are actions that could have brought Gerald and Mark in contact with their agency.

12) To sensitively involve the family, friends and where possible the informal networks of Gerald and Mark in the review.

13) To consider an approach to the perpetrator to inform learning.

14) To ensure at all stages of the process that as far as possible the "voice" of Gerald is reflected in submissions to this review.

15) To co-ordinate and have due regard with any other relevant parallel review processes.

16) To establish a clear action plan for individual agency implementation because of any recommendations.

17) To establish a multi-agency action plan in relation to any learning and improvement arising out of the Overview Report.

18) To provide an executive summary.

19) To conduct the process as swiftly as possible, to comply with any disclosure requirements, and on completion, present the full report to the West Cumbria Community Safety Partnership.

Scope of the Review

i. Time period – June 2019 – June 2020

The panel decided that the review Individual Management Reviews, information reports and overview report should focus on the period 12 months prior to the homicide with chronologies to cover 5 years, (except for Police and Probation who have specific dates to consider shown below).

ii. Individual management reviews (IMR) and other reports in respect of the subjects

Individual management review or information reports to be requested from the following organisations:

- General Practitioner – Solway Health Services

Chronology and information reports will be requested from additional organisations as follows:

- Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
- Cumbria Constabulary

- Her Majesty's Prison and Probation Service
- Department of Work and Pensions
- North Cumbria Integrated Care NHS Foundation Trust
- North West Ambulance Service
- Riverside Housing

All chronologies, individual management reviews and information reports should be completed and returned by the following dates.

IMRs and information reports to be submitted by 11th April 2022

All individual management reviews and information reports should focus on events from June 2019 up to the date of the discovery of the homicide 2020. If, however, any agency has relevant information outside of this period (both prior to and post death if applicable), this information should be included in the individual management review or information report. Furthermore, these dates may change if it becomes apparent to the Independent Chair that the timescale in relation to some aspect of the review should be extended.

All agencies should include all relevant information about both Gerald and Mark.

The review will consider all protected characteristics, as defined by the Equality Act 2010. The review will consider any additional vulnerabilities relevant to the individuals concerned. At the outset, disability has been identified as relevant to this review.

iii. Key lines of enquiry

The review should address both the 'generic issues' set out in the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) and the following specific issues identified in this case:

1. To describe and analyse the events which led up to the fatal incident.

2. To establish an understanding of agency involvement with Gerald and Mark in the 12 months prior to the homicide.

3. Were services responsive and accessible to Gerald?

4. Were services responsive and accessible to Mark?

5. Were any service responses to the subjects affected by the COVID19 pandemic (review each contact/response with current impact at that time)?

6. Was information shared in a timely manner and to all appropriate partners during the period covered by this review?

7. To explore whether there is any evidence or information which may indicate that there was coercive or controlling behaviour or abuse in the relationship.

8. To examine whether there is anything in the perpetrator's background which might explain his character and his behaviour which led to the homicide.

9. Are there areas that agencies can identify where national or local improvements could be made to the existing legal and policy framework?

iv. Specific issues for individual agencies

National Probation Service and Cumbria Police to provide any relevant earlier offending history contact regarding Mark.

Terms of Reference were agreed on 01/03/2022.

Appendix 2 - Review Recommendations/action plan.

Recommendation 1:

Safer Cumbria (Combatting Drugs Partnership) to ensure that the 2022 drugs needs assessment considers the profile of New Psychoactive Substances to assist in informing the design of local strategies to support the reduction of serious violence and associated harms.

Desired outcome from the recommendation – *Assurance from Safer Cumbria (Combatting Drugs Partnership) that strategies include psychoactive substances when considering the reduction of serious violence and associated harm.*

REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Completion Date and Outcome
1.1	**The drugs needs assessment is an ongoing/ work in progress and should be completed by the end of October. Whilst psychoactive substances are not a specific item per se, the themes, objectives and wider agenda items covers drugs harm and linked violence reduction.**	County wide	*Safer Cumbria*	**NPS was raised through the Addictions Board and was referenced in the Needs Assessment, but the numbers in Cumbria were too low to be statistically significant in terms of data provision.**	**Oct 22**	COMPLETE 14/09/23 – confirmation that NPS is referenced in the Combating Drugs Needs Assessment and has been agreed by the Addictions Board to be monitored during future data updates and recognising links to violence or associated harm.

Recommendation 2:

That when risk of harm to others is indicated by patients to health practitioners, assessments of who may be at risk should be considered.

Desired outcome from the recommendation – *to ensure there is a clear pathway to identify those who may at risk of harm.*						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
1.1	**Ensure this is added to relevant Health Pathways.**	County wide	*Primary Care*		**Dec 2022**	COMPLETE. Information added to Health Pathways and are readily available to Primary Care.
1.2	**To ensure any telephone script for telephone assessments includes those who may it at risk of harm.**	County wide	*Primary Care*	All systems reviewed.	**Dec 2022**	COMEPLETE. A decision has been made not to introduce scripts for assessments. All information is held within the Health Pathways instead.

Recommendation 3: **That where it is possible to do so, health agencies should consider whether records can indicate key family information and as a minimum childcare responsibility.**						
Desired outcome from the recommendation – *To ensure those with caring responsibilities are identified and clearly flagged on healthcare systems.*						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
1.1	**Review Current systems to include details of who the patient is a**	County wide	*Primary Care*	All systems reviewed.	**Dec 2022**	COMPLETE.

	carer for both children and adults in vulnerable circumstances. **Including an expectation that this information is updated with relevant changes and referred to when considering risks and impact on others.**					Information added to Health Pathways and are readily available to Primary Care.
1.2	**To continue to use the core assessment to ensure those with caring responsibilities are flagged and to review regularly to ensure information is up to date.**		*CNTW*			COMPLETE CNTW core assessment includes a section to obtain Carers / Relatives / Views and Information from Third Party Sources with prompts to establish - Does this person have a carer - Carers/relative views and expectations - Carers Assessment required With prompts to complete carer information There is also a section on Caring Information which requires staff to establish any caring responsibilities including who is involved in providing care to the service user

						and if any of those carers are under 16 years old. Questions are also asked if the service user has any children and where they live. Children's details also need to be included.

Recommendation 4: ***West Cumbria Community Safety Partnership to ensure that domestic abuse training reflect inter family violence as well as intimate partner violence.***						
Desired outcome from the recommendation: To ensure multi agency training is delivered to encompass all forms of inter family and intimate partner violence.						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
1.1	**To ensure training is delivered across all agencies to embed the different forms domestic abuse and violence can present as and the tools used to risk assess.**	County wide	*Domestic Abuse Group and CSP's*	Rolling programmes of training introduced.	**Sept 2023**	**COMPLETE:** Cumbria County Council have commissioned the following services: • Victim Support Cumbria to deliver DA Risk Assessment and Safety Planning Training. This will cover raising awareness of all types of DA including inter familial and intimate partner

						violence. At the start of March 2022 roll out is at 50% with an expected cohort of 600 colleagues. • SafeLives DA Matters Train the Trainer. This training is to train 25 trainers across the partnership, co delivery with a SafeLives Trainer then rollout across the partnership. This includes raising awareness of all types of DA including inter familial and intimate partner violence. This programme will allow for regular training dates to be released. • Cumbria Constabulary have commissioned Safelives to deliver DA Matters Train the Trainer. This is complete and the competent trainers are now delivering this across Cumbria Police staff. As of early October 2023, 800 police staff will have been

						trained. This includes raising awareness of all types of DA including inter familial and intimate partner violence. • All Primary Care staff are able to attend DA Matters Training or to attend "How Safe Do You Feel?" training provided by NCIC. • Primary Care to introduce DA Champions. Practices to nominate a clinician within their practice (who is in a leadership role e.g. GP or Lead Nurse) who will become a Champion within their practice to support the domestic abuse agenda, attend a training course, engage with the practice to bring about change and increase awareness (including use of the routine inquiry) and create practice plan for improvement, before attending a second study day later in the year to share learning and network further (note – it will be expected that the same person will attend both sessions except in exceptional circumstance e.g. maternity leave).

Appendix 3 – Individual Agency Recommendations

Recommendation 5: **All clinical and administration staff to received Domestic Abuse Training**						
Desired outcome from the recommendation – *To ensure that all Clinical and Administration staff receive training in Domestic Abuse.*						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
5.1	**To ensure training is delivered across all staff to embed the different forms domestic abuse and violence can present as and the tools used to risk assess.**	Local	*NENC ICB*	Training opportunities shared with the GP practice safeguarding leads.	**Dec 22**	**COMPLETE** All clinical and administrative staff have been encouraged to attend either Responding Well DA training provided by the Local Authority or Domestic Abuse training provided by NCIC.

Recommendation 6: **Domestic Homicide Review process awareness will be provided for Lead members of the Practice**						
Desired outcome from the recommendation – *Lead members of the practice will be aware of the DHRs and the relevant responsibilities involved.*						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**

6.1	**Domestic Homicide Review processes to be shared with all lead members of the practice.**	Local	*NENC ICB*	All processes shared with relevant members of staff.	**31/07/22**	COMPLETE The practice Safeguarding Lead is part of the Safeguarding Leads Network where DHRs are regularly discussed.

Recommendation 7:

A Single Point of Contact should be established in every case which meets the statutory Review threshold within each Primary Care Practice and raised as a risk during organisational change.

Desired outcome from the recommendation – *Single points of contact will identified for all cases meeting the need for a statutory review.*

REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Completion Date and Outcome
7.1	**Single Points of Contact to be identified for all GP practices.**	Local	*NENC ICB*	SPOCS identified and if/when there are organisational changes this is raised as a risk.	**Dec 22**	COMPLETE All GP practices now have Safeguarding Leads and points of contact

Recommendation 8:

All clinicians to be advised to ensure consistency in using clinical templates and system prompts. The practice will request that prompts contain reference to drug and alcohol misuse.

Desired outcome from the recommendation – *All clinicians will use the appropriate pathways*

REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Completion Date and Outcome
8.1	**Health Pathways to be created to ensure consistency across Primary Care**	Local	*NENC ICB*	Pathways created and embedded into practice.	**Dec 22**	COMPLETE Information added to Health Pathways and are readily available to Primary Care staff

Recommendation 9: **Learning from the DHR to be shared within the practice incident and clinical meetings.**						
Desired outcome from the recommendation – *All staff within the GP practice will be aware of the learning from this DHR*						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
9.1	**The DHR and associated action plan to be shared with the practice incident and clinical meetings.**	Local	*NENC ICB*	A Health Safeguarding Leads network has been established. Learning from statutory reviews is regualry shared with the network	**March 24**	ONGOING. Safeguarding Lead attends the network and has also attended the recent DA Strategy development day.

Recommendation 10:

All clinicians to be advised to seek guidance from the new practice Safeguarding Adult and Safeguarding Children Lead GPs						
Desired outcome from the recommendation – *All clinicians will seek advice and guidance from the practice GP Leads*						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
10.1	**All safeguarding pathways to be updated and embedded in practice.**	Local	*NENC ICB*	All health pathways updated and embedded. All relevant safeguarding information held on the Team Net portal.	**Dec 22**	COMPLETE Safeguarding Leads attend the Safeguarding Network. Health pathways regularly reviewed and updated.