Executive Summary

Domestic Homicide Review

In respect of

Mr. E

Died June 2015

Chair of Review and Report Author: Kam Sandhu

August 2018

(Updated July 2021)

1 Contents

Introduction

The Independent Chair and Review Panel members would like to express their sincere condolences to Mr E's family. We are very grateful for their time and participation in this review, and we have valued their contributions to it.

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

1.2 A duty on the relevant Community Safety Partnership to undertake Domestic Homicide Reviews, along with associated procedural requirements, was implemented by the *'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews'* in April 2011 (updated in 2013 and 2016 respectively). This defined a Domestic Homicide Review (DHR) as:

- a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse, or neglect by,
- a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
- a member of the same household as himself.
- held with a view to identifying the lessons to be learnt from the death

1.3 The purpose of a DHR is to

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

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

c) Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

d) Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

e) Contribute to a better understanding of the nature of domestic violence and abuse; and

f) Highlight good practice.

1.4 The review excludes consideration of how the victim died or who was culpable; this is a matter for the Criminal Courts and Coroner respectively to determine.

Scope of the DHR

1.5 The review will consider the period that commences from 1st August 2010 up to and including the date of the victim's last attack which was on the 9th November 2012**;** should agencies identify any matters that are germane to the review outside of this review period it should be captured and reported as antecedent history and discussed with the Chair/Panel. It was agreed that the timeframe of two years was proportionate and appropriate, given that more than two years had already passed since the critical incident (2012). It was noted that the scope of the review would allow exploration of a significant previous incident which resulted in the perpetrator having a conviction for assaulting the victim. Any significant events outside of the review timescale could be captured in antecedent history.

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

Name	**Mr. E**	**Mr. Z**
Relationship	Friend/ partner	Friend/ partner
Date of Birth	1954	1981
Date of Death	June 2015	N/A
Ethnicity	White British	White British
Sexuality	Homosexual	Heterosexual
Address of Victim:	Cannock, Staffordshire	

1.6 Key issues to be addressed within this Domestic Homicide Review are outlined below as agreed at the Scoping Meeting. These issues should be considered in the context of the general areas for consideration listed at Appendix 10 of the 2013 National Guidance.

- Identify significant incidents and events and identify whether practitioners and agencies responded appropriately.
- Consider if practitioners and agencies involved followed appropriate interagency and multiagency procedures in response to the deceased's needs?
- Establish whether single agency and interagency responses to concerns about Mr. E's needs and welfare, and the assessment of risk to himself and others was considered and appropriate. In particular whether agencies assessed his vulnerability within the safeguarding context as an adult with vulnerabilities; and what subsequent steps were taken to manage his increased level of risk.
- Did agencies recognise issues of domestic abuse and or safeguarding and make the necessary referrals and in a timely way?
- Was information relating to risk assessments shared between agencies? Had information been shared, and if so, was it shared appropriately?

- Identify any areas where the working practices of the agency had a significant, positive or negative, impact on the outcome.
- Identify any gaps in, and recommend any changes to, the policy, procedures and practice of the agency, and interagency working, with the aim of better safeguarding for vulnerable adults.
- Establish whether there are lessons to be learned from the case about the way in which local practitioners and agencies carried out their responsibilities and duties, and worked together to safeguard Mr. E, the family and the wider public, for example there were attendances from more than one agency on several occasions, services were often rejected by the victim, what steps were taken to reduce the chance of repeat victimisation, or the opportunity for a prosecution not led by the victim?
- Both the victim and perpetrator were alcohol dependent, were there adequate interventions and support offered by specialist services to help and support the victim and or perpetrator.
- Were mental health issues actively considered by agencies, for both victim and perpetrator; this includes mental capacity as well as addressing broader mental health concerns.
- Consider whether there was an element of coercion or control within the relationship; There may have been elements of coercion/influence in this relationship based on certain factors, for example, there was an age difference, financial gain by the perpetrator, whether either party wanted/did not want an intimate relationship; all of which could have led to exploitation of the victim.

1.7 Contributors to the Review

Organisations **that were required to complete Individual Management Reviews**

1. National Probation Service
2. Staffordshire Police
3. West Midlands Police
4. Staffordshire and Stoke on Trent Partnership NHS Trust (SSOTP)
5. Staffordshire County Council Adult Protection
6. University Hospitals of North Midlands NHS Trust (UHNM)
7. South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group

Organisations that were required to complete Summary Reports

1. West Midlands Ambulance Service (WMAS)
2. ARCH North Staffs
3. The Royal Wolverhampton Hospitals NHS Trust
4. Addiction Dependency Services (ADSIS)
5. South Staffordshire & Shropshire Healthcare NHS Foundation Trust
6. Cannock Chase Council
7. Heantun Housing Association

1.8 Review Panel Membership

The panel met on eight occasions and made a number of recommendations. All members were independent of line management of staff connected to this case. It consisted of the following organizations and individuals:

- Independent Chair and Author – Kam Sandhu
- Arch (North Staffs) Ltd – Richard Hughes; Independent Domestic Violence Adviser and Male Victims Worker
- Cannock Chase Council – Kerry Wright; Partnerships, Community Safety and CCTV Manager
- National Probation Service – John Mason; Deputy Head, National Probation Service – Staffordshire & Stoke-on-Trent
- South Staffordshire Clinical Commissioning Group – Lisa Bates; Lead Nurse, Adult Safeguarding
- Staffordshire and Stoke on Trent Partnership NHS Trust – Karen Nixon, Professional Lead In Social Work, Nursing and Quality Directorate
- Staffordshire County Council – Ruth Martin; Safeguarding Team Leader, Staffordshire Adult Safeguarding Team
- Staffordshire County Council – Julie Long; Principal Community Safety Officer
- Staffordshire Police – David Mellor; Policy, Review & Development Team Manager
- University Hospitals of North Midlands NHS Trust – Nicky Cooke, Site Matron – Nursing & Operations
- West Midlands Police - Michaela Kerr; Detective Chief Inspector, Public Protection Unit

1.9 Review Panel Chair and Overview Author

The Partnership agreed to invite Kam Sandhu to Chair and Author the Review.

Ms. Sandhu was known to be someone who had the requisite skills, knowledge and experience to take on this responsibility (set out in paragraph 5.10 of the National Guidance 2013). Ms. Sandhu has completed a number of domestic homicide reviews within the East and West Midlands. An experienced non-executive director, with a strong commitment to understanding domestic abuse; she has worked with women's refuges and Chaired an independent scrutiny committee into domestic abuse in Nottinghamshire. Having worked within the public sector for over twenty years she has a clear commitment to partnership working to provide the very best services to survivors and victims. She has produced academic research into forced marriage as part of her MSc in Criminology Ms. Sandhu is independent of the Chase Community Partnership and confirms she has no direct association with, nor is an employee of any of the agencies involved. There are no known conflicts of interest which would prevent her from taking responsibility for chairing or authoring the review panel.

1.91 Terms of Reference

The Terms of Reference (TOR) for this Domestic Homicide Review (DHR) have been drafted in accordance with the DHR guidance for the Conduct of Domestic Homicide Reviews (December 2016).

1.92 In summary the TOR required agencies to consider a range of issues pertinent to this case, in particular to understand the impact of the alcohol addiction on both the perpetrator and the victim and how this affected the provision of and access to services. Agencies were asked to reflect on the risks and vulnerabilities of the victim and whether single agency actions and multi-agency actions were appropriate and fully cognisant of the risks and vulnerabilities. Agencies should be alert to the increasing levels of risk to the victim and consider if there were any clear disclosures around domestic abuse. Agencies were asked to reflect on any information they may have had which suggested that the victim was being exploited financially or emotionally as well as issues relating to his sexuality.

2.0 Summary of the review

2.1 In November 2012 Mr. E (male, homosexual, late fifties) was physically assaulted by Mr. Z (male, heterosexual, early thirties) and suffered a severe head injury; both were heavily under the influence of alcohol; Mr. E did not regain consciousness and remained in a Care Home until his death in June 2015.

2.2 Mr. E and Mr. Z lived within the West Midlands and had been known to each other since 2000; they were neighbours and socialised together, much of this involving alcohol. Mr. Z became homeless and moved in with Mr. E in 2003 and in 2006 Mr. E moved back to Cannock to be closer to family. Mr. Z also spent much of his time at the same address and for all intents and purposes lived in the same household as Mr. E since that time.

2.3 Both Mr. E and Mr. Z were well known to a number of agencies; the two police forces involved in this case record that Mr. Z had eighteen crime offender records between 1997 and 2012 and two records of Actual Bodily Harm (ABH) against Mr. E (2004 and 2005). There were also several historic domestic abuse offences recorded against Mr. Z's female partners during that time. The local police service reported eleven service call outs to the home address between April 2011 and July 2012.

2.4 The medical services referred to as the MIU (Minor Injuries Unit) recorded thirty-nine visits by Mr. E between 2011 and 2012. The GP had records showing fifteen injuries (several of which were head injuries) sustained by Mr. E during the same period.

2.5 The review revealed that Mr. E and Mr. Z were regularly together and frequently under the influence of alcohol when in contact with agencies; the family reported that they spent time together both within the home and outside. Mr. E had repeated injuries associated with assaults and alcohol intoxication. Both Mr. E and Mr. Z were afflicted with health problems associated with heavy regular drinking, including convulsions.

2.6 When an altercation took place, Mr. E would sometimes call his family who, in turn, would contact the police; police would attend but both Mr. E and Mr. Z would either not cooperate or state that there was nothing going on. It is clear that there were occasions when Mr. E feared Mr. Z but would not engage with agencies trying to assist him. Any contact agencies did have was virtually always when Mr. E was under the influence of alcohol.

3. Key findings

3.1 **Injuries to Mr. E and risk assessment**

There were in excess of fifteen references to injuries sustained by Mr. E throughout the scoping period of this review and the MIU referenced thirty-nine visits in two years. Most of those related to injuries sustained whilst under the influence of alcohol and often resulted in an injury to the head. Agencies might have identified some pattern and considered the nature of the relationship and risks posed to Mr. E. However, in this case this was not considered; Mr. E's repeat injuries were not linked, reported, or shared with any other agency until 2012. The Multi-Agency Safeguarding Hub (MASH) Information Sharing Discussion Document was completed, however the follow up actions were deficient.

3.2 **Mr. Z's history of violence**

3.21 Mr. Z had a lengthy history relating to violence often against his female partners. He was convicted of an assault on Mr. E in May 2012, however ineffective assessment of victimisation and previous violence led to incomplete risk assessments until July 2012.

3.22 In July 2012 opportunities for action as part of the MASH Information Sharing Discussion Document (MISDD) to safeguard against future victimisation did not go far enough, though evidence suggests that Mr. E would not have engaged with agencies to support him in any event.

3.3 **The Impact of alcohol dependency for both Mr. E and Mr. Z**

3.31 Both Mr. E and Mr. Z were regularly using alcohol and, in some cases, reported consuming forty units per week. There is no record of alcohol support interventions for Mr. E via the Primary care gateway or indeed from any other agency making a referral; the only reference to discussion about alcohol abuse was in October 2012 when Mr. E refused services from his GP.

3.3.2 Mr. Z had a lengthy and complex relationship with alcohol and came from a family of heavy drinkers; his drinking often resulted in violence. This is well evidenced in the number and range of violent assaults he was involved in since his youth. Mr. Z also suffered from alcohol related seizures throughout the review period; he attended GP services as well as hospital and at times recognised that he needed help with his excessive drinking. Attempts were made for referral to addiction agencies to support

him, but his chaotic lifestyle did not help him to take up these services, even when he showed some inclination to do so. It appears that timely and appropriate referrals were made for Mr. Z.

3.4 **Capacity for decision making/ service refusal**

3.41 Mr. E was contacted as part of an assessment by Social Services to consider if he had "capacity" to make decisions; the "assessment" was carried out whilst Mr. E was under the influence of alcohol, on the doorstep, with Mr. Z also present and no reference to the GP. These conditions are far from the professional ideal and fall someway short of an effective assessment. It was therefore unsurprising that Mr. E did not want any further contact.

3.42 However, Mr. E was not keen to engage with support services and this is corroborated by family members who stated that he was reluctant to engage with agencies, in particular the police. The panel specialist advisor notes "Gay men are (one to four) times at higher risk of Domestic abuse than heterosexual men. Gay men are often victims of hate crime. Older gay men tend to have suffered a high level of homophobic attitudes from agencies/services". These factors may well have contributed towards the reluctance that Mr. E expressed in engaging with services.

3.5. **The nature of the relationship between Mr. E and Mr. Z**

3.51 Mr. E's personal circumstances were largely invisible to agencies. Despite efforts on some occasions to understand his personal circumstances, Mr. E was not judged to be in a relationship with Mr. Z, although there were several references to Mr. Z being his partner, tenant, friend, drinking buddy. There was a degree of co-dependency between the two men, whether for some form of financial benefit (Mr. Z lived rent free, did not pay for food and regularly drank alcohol with Mr. E) or indeed some form of emotional crutch for Mr. E.

3.52 There was evidence of some third-party reporting of Mr. E and Mr. Z being partners; reflected in initial call types as "domestic" from police response but on arrival the two would be under the influence of alcohol and say they were friends or housemates. It was noted that same sex relationships are not always easy to be open about thus the nature of their relationship may have been too readily accepted as friends by agencies. "Traditional" notions of domestic abuse i.e., those in a heterosexual setting with the victim usually being a woman, may have shrouded a violent and abusive domestic relationship. The essence of this case still remains that opportunities to consider risk and vulnerability were missed, which might have seemed more obvious in a "heterosexual" relationship.

3.6 **Lack of cooperation/ engagement with agencies**

3.61 Wherever agencies had engaged with Mr. E to offer support or initiate dialogue, these were invariably declined. A significant opportunity in July 2012 to hold a "Professionals meeting" about any next steps would have been appropriate; this did not happen. This meeting would have enabled agencies to have a formalised multi agency discussion about the risks posed by Mr. Z to Mr. E and would have enabled them to outline a clear plan of action.

3.62 Mr. Z wanted help with his excessive drinking, but he too often missed appointments; his lifestyle was chaotic, and he had a history of addictions. Some effort was made to encourage him to engage with services, but this was not enforceable through any formal route.

3.7 **Communication between agencies**

3.71 There was evidence of some effective information sharing between agencies e.g. in July 2012 the safeguarding referral to Adult Social Care resulted in a MASH information sharing opportunity between probation, the police, hospitals and addiction services. However, opportunities to share information at an earlier stage were not taken, for example in May 2012 when Mr. Z was on a Suspended Sentence Order there were calls made for assistance to police from Mr. E's address, yet no connection was made with Mr. Z's previous violent history. Mr. Z was a known offender with a track record relating to violence over several years and preceding the scope of this review, yet this did not "trigger" any follow up activity. Opportunities to cross reference information held on OASYS and PNC (relevant history) might have led to more effective and proactive management of a violent offender.

3.78 It is apparent that there were gaps in the information that agencies held, and consequently a limited picture of the circumstances and issues relating to Mr. E and Mr. Z. Practitioners did not seek to gain further information or show adequate professional curiosity, furthermore Mr. E did not proactively engage with agencies; this did not aid the situation. Notably the GP was not part of ANY of these critical communications but would have added value to the discussions.

3.8 **Record keeping**

3.81 There are several examples within the scope of the review where insufficient regard was given to record keeping, for example, there is an absence of records from 20 July 2012 until 15 August 2012 from Social Services, so it remains unclear what contact was made and what involvement there was with Mr. E; this is problematic from an audit and safeguarding perspective.

3.82 A significant factor in record keeping is the lack of information around Mr. Z's previous convictions in May 2012; this led to incomplete references within reports (Standard

Delivery Report, an initial report which looks at the degree of culpability of the offender and the offence, attitude to the victim).

3.83 The panel found that the court administrative process for arrest warrants in 2012 was cumbersome and problematic as it was a paper-based system and operated by Court Enforcement Officers. The new system is an electronic system and is easily accessible for interrogation of data by relevant agencies.

3.82 In general some of the factors affecting issues around record keeping are impacted by the fact that different agencies have a whole range of record keeping systems; this can lead to less effective calibration /pooling of information, however it does not preclude agencies from sharing information with one another appropriately.

4. Conclusions

4.1 Mr. E was a gay man living in a fairly conservative community. He had long established links with the locality, in particular family who lived close by and who supported him with his finances and domestic tasks and saw him on a regular basis.

4.2 He was known to have lived with Mr. Z since approximately 2004, a man much younger than himself who had a significant history of violence towards others. Mr. Z is a man in his early thirties with a history of drug addiction and alcohol dependency. He was regularly in touch with Mr. E and stayed at his house rent free and would often be seen drinking with him in local public houses or at Mr. E's home.

4.3 A lack of professional curiosity about the conflicting information regarding the nature of the relationship between Mr. Z and Mr. E led agencies to underestimate the risks.

4.4 Agencies missed vital opportunities to intervene; the most significant being when Mr. Z was on a Suspended Sentence Order (SSO) and remained living with Mr. E without any exclusions or conditions attached to his sentence.

4.5 The hospital made an appropriate referral to the emergency team for an assessment on 7 July 2012, this was dealt with rather superficially over the telephone. However, when the second referral came in a week later a more robust approach was taken to securing and sharing information with other key partner agencies. A MASH Information Sharing Disclosure Document (MISDD) was completed. Whilst this was effective information sharing within the MASH, it did not go far enough in dealing with the high-risk Mr. Z presented; a professionals meeting/formal strategy discussion did not take place and should have done. The action following the information sharing was inadequate, given the ongoing risk to Mr. E; he was sent a letter advising him of local police support and alcohol support services.

4.6 The Community Safety Hub did not exist at that time but would have been an appropriate place to have sent a referral such as this.

4.7 There is no acknowledgment that Mr. E was gay in any of the interactions with the different agencies throughout the scope of this review and this may have led to a detriment in access to services for him as a gay man. This is set within the context of higher levels of domestic abuse faced by gay men, including hate crimes as suggested by Stonewall the Gay British Crime Survey 2013; this may well have compounded his fears about speaking to agencies openly about his sexual orientation.

4.8 Conversations about access to support services should not have taken place with Mr. Z present; this is poor practice. Mr. E should have had the opportunity to be spoken to when he was sober, away from Mr. Z, and possibly supported by a member of his family; this did not happen and falls short of best practice.

4.9 It must be acknowledged that Mr. E was reluctant to access services, and this would have made it difficult for agencies to engage with him. There was no formal mechanism to force Mr. E to stop socialising with Mr. Z, but this does not detract from the fact that Mr. E should have been informed of the risks he was exposed to, whilst being sober and coherent in order to make an informed choice. Mr. E's lack of engagement is of course problematic, and some attempts were made to offer services, but overall agencies should have sought to engage Mr. E on an individual basis to ensure that the reality of his situation was properly understood by all concerned.

4.10 The GP is largely passive in this case and did not link any of the repeat injuries as issues for concern; there is insufficient evidence of timely referral for alcohol support services for Mr. E. Agencies regularly came into contact with Mr. Z and Mr. E, almost always when the two men were under the influence of alcohol. This was seen as a lifestyle choice and agencies might have shown a more proactive approach by making referrals to appropriate services, even if they were not taken up.

4.11 After the assault in April 2012, for which Mr. Z was convicted, there were errors in probation practice and procedural hiccups which resulted in incomplete information being used in order to risk assess Mr. E and Mr. Z.

4.12 There is agreement that the relationship between Mr. E and Mr. Z did not necessarily fit the Domestic Abuse definition as there was inconclusive evidence that they were intimate; however, agencies missed opportunities to appropriately assess risk and vulnerability and to take up measures in a timely way to offer support and options to Mr. E in order to reduce the chance of him being a repeat victim.

4.13 Agencies responses appear to be 'real-time' to repeat incidents but there is no drawing together or cataloguing of them to build up a picture; this seems to have resulted in a rather scattergun and silo approach. This case highlights that the low level drunken incidents typical of the attendance of police and the ambulance service

during the review period would not necessarily have alerted concern in isolation, but information about previous incidents and repeated injuries and hospital visits might well have alerted them to deeper concerns around safeguarding. Information about Mr. Z's violence should have been available and linked together and might have raised more significant concern and triggered further action. Protocols for information sharing were already in place but not utilised to the best effect.

4.14 It is highly unlikely that agencies could have prevented Mr. E's death. Without intervention, episodes of violence were always likely to continue. The nature, frequency and ferocity of that violence and the resulting seriousness of the injuries sustained were far more difficult to predict.

5. Lessons learned

5.1 By exploring the lessons to be learnt in this case it is important to note that it appears that no single agency contact could have prevented Mr. E's homicide, however there are a number of areas where there are lessons to be learnt.

- Agencies should be better informed about domestic abuse and same sex partnerships, none of the agencies involved recognised Mr. E as a gay man. There should be better understanding around the structural and individual barriers faced by the LGBTQ community. Ensuring that services are proactive in removing barriers which may exist to ensure that there is Equality of Access is necessary. Formal recording of client's sexuality could assist in shaping and delivering better more accessible services.

- Although contact with the GP Services were medically appropriate there were opportunities missed to identify any domestic abuse concerns i.e. a lack of exploration around the persistent and repeated injuries sustained by Mr. E over the review period. Acute medical services now record those who attend 'frequently' this enables discussion around risks and patterns.

- The procedural failures from the probation service, though not systemic in the panel's view, were significant missed opportunities and all the learning from this review and their SFO (Serious Further Offences) review should have been implemented.

- The opportunity to hold a professionals meeting was missed. The policies and structures at that time allowed for such an intervention, however it was not pursued and should have been. More accountability for decision making around actions and inaction should be put in place.

- Repeated call outs to the police were dealt with as low-level nuisance calls; the opportunity to assess risk was missed due to lack of clarity about the nature of the

relationship (it was not deemed IPV or AFV) and poor intelligence. More robust contact between police and probation would have enabled better information sharing.

- Alcohol addiction played a significant part in this case. Both Mr. E and the perpetrator often used alcohol excessively and this was a barrier for agencies to ascertain a clear picture; however, the panel acknowledged that opportunities to engage with the victim, whilst not under the influence of alcohol were not taken. Nor were the wider family enlisted to support.

6. Recommendations

6.1 To improve information sharing protocols between the MASH and Cannock CSH (Community Safety Hub) and consider adopting this protocol across the County.

6.2 To enhance the profile and understanding of the role and function of the CSH.

6.3 In ALL cases agencies should ensure that an evidence-based decision is recorded when a Professionals meeting is NOT pursued. In particular where:

- There is non- engagement from the client
- High risk
- Multi agency involvement

6.4 To identify a mechanism to share information with the CSH where acute medical services have identified high risk/frequent flyer status, in order to promote effective partnership working.

6.5 Sexual Orientation is one of the protected characteristics under the Equality Act 2010. It is recommended that all agencies, particularly those that have a duty under the Public Sector Equality Duty (s149 of Equality Act 2010) record data relating to sexuality, in order to promote inclusivity, develop standards of service, and develop good equality practice. This information should be sought from both victims and perpetrators. NHS guidelines now request that Healthcare services record this data.

6.6 To share the learning from this review within agencies and to disseminate it across the Community Safety Partnership to promote partnership working.

6.7 To coordinate a campaign raising awareness on issues affecting the hard to reach as well as those with vulnerabilities as highlighted in this case: alcohol /substance misuse, mental health, male victims of violence.

6.8 To promote sufficiently tenacious contact with victims, promoting access to pathways for support services where there is a known, repeat perpetrator.

6.9 The Community Safety Partnership to co-ordinate an awareness campaign for members of the public around Clare's Law*.

(*Clare's Law, or the Domestic Violence Disclosure Scheme, gives any member of the public the right to ask the police if their partner may pose a risk to them.)