Chase Community Partnership

Cannock Chase Community Safety Partnership

OVERVIEW REPORT

DOMESTIC HOMICIDE REVIEW

in respect of

Mr. E

July 2019

Independent Review Panel Chair and Author: Kam Sandhu

Updated: March 2021

CONFIDENTIAL

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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 Neighbours heard noises in the street and found Mr. Z stamping on the head and body of Mr. E.

1.2 Mr. Z was subsequently arrested by police and Mr. E was taken to hospital where it was found that he had sustained several injuries, including a severe head injury

1.3 A police investigation commenced, and Mr. Z was charged with an offence of Wounding with Intent – Contrary to Section 18 Offences Against the Persons Act 1861. He was subsequently convicted and sentenced to over an eleven years term of imprisonment.

1.4 Following the assault Mr. E was moved to a care home, he had been diagnosed with Cerebral Atrophy, he was immobile, fed through a percutaneous tube and blind in his left eye.

1.5 Mid 2015, years after the assault – Mr. E died. An initial cause of death documented by an attending General Practitioner and communicated to Her Majesty's Coroner (HMC) was Bronchopneumonia, Immobility and Acquired Brain Injury.

1.6 A post-mortem examination was conducted. After detailed forensic pathology a causal link was established between the assault and his death.

1.7 The matter was reported by Staffordshire Police to the Crown Prosecution Service and was referred by them to the Cannock Chase Community Safety Partnership (CSP) as a potential Domestic Homicide.

1.8 A Scoping Panel was commissioned to consider whether a Domestic Homicide Review (DHR) was appropriate. The Panel considered whether the criteria for commissioning a DHR had been met. The decision was made that the circumstances did fulfil the requirements of a DHR, on the basis that the circumstances indicated that Mr. E's death was caused by the violent actions of Mr. Z and that they were members of the same household; there was the potential that they may have also been in an intimate relationship but there was insufficient information available at the time of commissioning the review to confirm this. The decision was made that the issue would be kept under review until such time as any further information or evidence emerged.

1.9 The recommendation to commission this review was endorsed by the Chair of the Chase Community Partnership who was present at the Scoping Panel meeting in August 2015 and the endorsement was recorded in the minutes.

1.10 This decision was communicated in a letter to the Home Office confirming that the Scoping Panel had recommended a DHR in this case.

Grounds for Commissioning a DHR

1.11 The relevant Community Safety Partnership (CSP) must always conduct a DHR when a death meets the following criterion under the Domestic Violence, Crime and Victims Act (2004) section 9, which states that a domestic homicide review is:

A review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse, or neglect by:

- A person to whom he was related or with whom he was or had been in an intimate personal relationship, or
- A member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.

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

A member of the same household is defined in section 5(4) of the Domestic Violence, Crime and Victims Act [2004] as:

- A person is to be regarded as a "member" of a particular household, even if he does not live in that household, if he visits it so often and for such periods of time that it is reasonable to regard him as a member of it;
- Where a victim (V) lived in different households at different times, "the same household as V" refers to the household in which V was living at the time of the act that caused V's death.

1.12 The purpose of undertaking a DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organizations work individually and together to safeguard victims.
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

1.13 Scope of the DHR

1.13.1 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	

1.13.2 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.

1.14 Matters for the Review Panel (in addition to the above)

- Identify from both the circumstances of this case, and the domestic homicide review processes adopted in relation to it, whether there is learning which should inform policies and procedures regionally or nationally.
- Consider aspects relating to the deceased and /or his friend/partner being vulnerable adults as defined by Home Office and Department of Health No Secrets 2000 “Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse (definition 8 section 2@2.3) – a person “who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of himself or herself, or unable to protect him or herself against significant harm or exploitation’. Reflect on whether Mr. E was an adult with vulnerabilities.

1.15 Excluded matters

The Review will exclude consideration of how Mr. E died or who was culpable- that is a matter for the Coroner and Criminal Courts respectively to determine.

TIMESCALES

1.16 This review began in August 2015 and the report was concluded in May 2019. At the time of the scoping panel, Staffordshire Police were in the process of considering further prosecution, awaiting the outcome of the post mortem, consequently there were delays in the progression of the DHR due to the

ongoing investigation, which finally went to Court in 2016. In the meantime, the Panel were able to gather chronological information to share and discuss any emerging issues, the Senior Investigating Officer was invited to all meetings to safeguard Disclosure concerns. There were some operational challenges for the CSP/ Staffordshire CC which led to some of the additional delays. This review has been significantly delayed by the coronavirus pandemic, with impacts on the preparation and finalisation. Whilst this was an unavoidable issue it is regrettable for all involved.

Confidentiality

1.17 The Chair met with family members first in July 2017 and then May 2019 to outline the findings of the report and clarify their wishes around anonymity of the victim within the report. The family rejected the use of a fictional first name and instead preferred Mr. followed by a letter of the alphabet; this request has been honored within this report.

Terms of Reference

1.18 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) See Appendix 2.

1.19 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.

Methodology

1.20 The agencies involved were asked to complete Individual Management Reviews (IMRs) of the work their own agency did with both parties. As part of this process the key staff who had first-hand contact with either Mr. E or Mr. Z were interviewed by the agency author, and their views were incorporated into the IMRs. Agencies that did not have direct involvement or had only very brief contact with either Mr. E or Mr. Z were asked to complete Summary Reports.

1.21 The review panel met on eight occasions and the discussions and emerging themes have been reflected in this Overview Report.

Involvement of Mr. E's Family

1.25 The family of the victim are a crucial part of the review process and the Chair made contact with them as soon as was practicable. Mr. E's close family

members were sent a letter advising them of the DHR in the autumn of 2015, this was hand delivered and included a Staffordshire County Council leaflet named" *Domestic Homicide Review Information Leaflet"* as well as information relating to AFFDA. The Chair spoke on the telephone as per the request of one family member and visited the other. Any request to be involved/ or not with the review was honoured by the Chair after dialogue. Family members were invited to have a friend/representative to support them at the meeting. The family were explicitly consulted on the use of any pseudonyms and their preference honoured.

Involvement of Mr. Z

1.26 The Chair recommended that the perpetrator be interviewed as part of the review process; not only could this shed light on the nature of his relationship with the victim but also provide a perspective on their living arrangements. The Chair wrote to the Governor of the prison where Mr. Z was being held and requested contact. A letter was sent to Mr. Z who agreed to meet the Chair and a member of Staffordshire County Council.

Contributors to the Review

Organizations 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

Organizations 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

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

Review Panel Chair and Overview Author

1.27 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.

Parallel Reviews

Coroner's Inquiry

1.28. An inquest was opened on during 2015 and adjourned. In light of the successful prosecution and conviction HMC finalised that process.

1.29 In 2018 The probation service carried out an internal Serious Case Review and actions were incorporated into their action plan.

1.30 Equality and Diversity

1.3.1 The nine protected characteristics of the Equality Act 2010 are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

1.3.2 There were no equality and diversity issues for Mr. Z.

1.3.3 Mr. E was significantly older than Mr. Z and a white homosexual male, with some health issues, though he was not registered as having a disability. The Chair recognised the need for specialist advice on the panel and secured the attendance of an IDVA working with male client groups from the area. He was able to contribute to the discussions and comment on the impact of those protected characteristics on Mr. E and on Mr. E's ability to access local services.

1.3.4 One of the challenges of this case was that there was no definitive agreement on the sexuality of the victim nor whether he was ever 'in a relationship' with the perpetrator. The family held mixed views on the situation, the perpetrator suggested Mr. E was gay. Information gathered by agencies did not recognise Mr. E as a gay man and the panel debated at length why this might have been. Our panel expert was able to shed some light on this situation, he acknowledged that the local community was quite conservative, he mentioned the personal courage it might have taken Mr. E to 'come out' in the local area as well as the fact that there may have been some generational factors which might have inhibited Mr. E from disclosing.

1.3.5 The panel explored opportunities that may have been missed regarding Mr. E's Sexuality, e.g., when police and ambulance services attended or when there were visits to the GP/hospital; the panel acknowledged that none of the agencies had confirmation that Mr. E was gay, therefore it was difficult to ascertain whether services were adequately accessible to him. Agencies should be careful about making assumptions about someone's sexuality, but the fact remains that opportunities to ask the victim were missed; these missed opportunities could have had a direct impact on the quality and type of interventions available. These elements are discussed throughout this report and followed up in the recommendations. Structural and cultural barriers may have contributed to Mr. E not accessing services, but it is more likely that his individual and interpersonal barriers held greater weight in this case, anecdotally Mr. E may have had previous bad experiences with services or had concerns about homophobia in service delivery. Agencies involved in this review had equality policies in place and there was some evidence that pathways for referral were available and utilised by local

agencies. More generally it would be beneficial for agency professionals to continue to be better informed on the spectrum of gender identities to ensure that structural inequalities are not perpetuated, and more inclusive services are offered.

1.3.6 Heavy alcohol consumption played an integral part in this case, it may have exacerbated any willingness on the part of Mr. E to engage with local services. There is reference throughout this report of the alcohol misuse and addiction, both the victim and perpetrator came into contact with agencies whilst under the influence of alcohol; this presented challenges to professionals and may have impaired Mr. E's understanding of risk.

The Facts

Incident Giving Rise to the Review

2.1 Mr. E had lived at a property in Cannock rented to his sister since approximately 2006 and had known the perpetrator since approximately 2000. Late 2012 both Mr. E and Mr. Z were seen in an altercation on the street outside Mr. E's house.

2.2 Neighbours in the locality had called the police on seeing Mr. Z kicking Mr. E outside of the property late evening. The police and ambulance arrived, Mr. Z was arrested at the scene, and Mr. E was taken to hospital. He did not regain consciousness and required nursing care until his death in 2015.

Criminal Investigation

2.3 In October 2016, after consultation with the CPS, Mr. Z was charged with Murder. During 2017, over four years after the assault – Mr. Z pleaded Guilty to the Murder of Mr. E and was sentenced to life imprisonment.

Background Information

2.4 Mr. E had known Mr. Z for at least ten years. It appeared that they knew each other socially and would regularly drink alcohol together. They were neighbours in Wolverhampton. Mr. Z lived with his then girlfriend, but became homeless as a result of a breakdown in their relationship whereupon he moved in with Mr. E.

2.5 Several years later Mr. E moved from Wolverhampton to live with his mother in Cannock in order to care for her until her death. The victim's brother advised that Mr. Z also moved to this address and stayed there intermittently. Three years later Mr. E took over his sister's private tenancy and lived there with Mr. Z.

2.6 Mr. E had a girlfriend (pen pal) over twenty years ago, but his brother stated that he was gay. This was corroborated by Mr. Z when interviewed, where he stated that their relationship was platonic but that Mr. E "had tried it on with him". This had not previously been disclosed to agencies.

2.7 From the information within IMRs it appears that agencies involved with Mr. E did not know that he was a gay man, though several were aware that Mr. Z was living with him. This is relevant, had agencies been aware they may have chosen a different course of action, have been able to refer to specialist support agencies or consider any risk factors within the relationship. The GP records did not reference that Mr. Z was living with Mr. E.

2.8 The GP records an incident in 2004 where Mr. E leaves the surgery stating that the GP "hates gays". It could be inferred that by making this comment Mr. E was gay himself, but no official record exists. Between 2005 and 2008 there are no medical notes connected with Mr. E and the last record stated Mr. E had a head injury in the summer of 2005.

2.9 Staffordshire Police records suggest that some family members may have felt that Mr. Z was 'taking advantage' of Mr. E, i.e. having somewhere to live rent free and a regular drinking partner. There was also the suggestion that some family members were concerned for Mr. E as he had bruises and minor injuries from time to time, that he explained as accidents.

2.10 Mr. E was single and had been resident in Cannock for six years prior to the incident in 2012. Mr. E had local family connections and had regular contact with them. Mr. E was in receipt of disability benefits; his family reported that he had mobility problems, was blind in his left eye and had hearing loss in his left ear.

2.11 Mr. Z had had a number of female partners in the past and had a lengthy history of violence stretching from 1996 to 2017; with some fifteen offences including dishonesty, public disorder, and violence, ABH (Actual Bodily Harm) and Domestic Abuse. Mr. Z had some local family connections in that his parents lived in Wolverhampton; it is understood he had little contact with them.

2.12 Mr. Z's family history is a complex one. He was born in Wolverhampton, raised by his mother, met his father as an adult but had no ongoing contact with him.

2.13 Mr. Z had been drinking significant amounts of alcohol since the age of twelve, he came from a family of heavy drinkers. Mr. Z reported that he had been a drug user in the past.

Preamble

2.14 The panel had several useful discussions around whether the definition of domestic abuse could have reasonably been considered to have applied in this case; the key concern being; were Mr. E and Mr. Z ever in an intimate relationship; the panel found that there was only hearsay about them being in a relationship and concluded that the focus of the review was to consider risk and vulnerability of the two men who were living together. Indeed there was conflicting information throughout the period in scope regarding the nature of the relationship between the victim and perpetrator; some of the family suggested that Mr. E and Mr. Z were partners, the perpetrator said they were not and there were no clear agency records pertaining to them being in a relationship. The review did evaluate whether there was evidence available to agencies during the scoping period about any intimacy or known relationship but there was not; either because it was never asked of the parties concerned or agencies were told they were housemates/ buddies/ landlord and tenant etc.

2.15 Specifically, the panel discussed the relevance to the case of the current Cross Governmental definition of domestic violence and abuse which is:

> **"*Any incident of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. The abuse can encompass but is not limited to psychological; physical; sexual; financial and emotional.*"**

2.16 What is clear is that this case does satisfy the criteria for undertaking a DHR as both men in scope were adults, living together in the same household and there was violence between them resulting in the death of the victim.

2.17 The difficulties in applying the definition of domestic abuse arise out of a lack of clarity about whether the victim (Mr. E) and perpetrator (Mr. Z) were or had ever been intimate partners. The victim is understood to have been gay (by some family members who contributed to the review and by the perpetrator) and the perpetrator heterosexual; the perpetrator stated that their relationship was based on friendship and mutual social interests. It appears then that the domestic abuse definition is not strictly met but the author believes that there is benefit from considering this situation as an *idiomatic antithesis* i.e. not so much the ‘ letter of the law but the spirit of the law ‘ but in this case the spirit of the definition; the author has proceeded on this basis.

2.18 After all, the fact remains that Mr. E and Mr. Z lived in the same household, saw each other regularly and shared the same domestic space; physical abuse of the victim took place within and outside of the home and incidents were not isolated and were almost always fuelled by alcohol.

2.19 The issue of intimacy between the victim and perpetrator is less relevant than the fact that there were gaps in identifying, assessing and managing the victim’s vulnerability, information was accepted at face value about the relationship i.e. that they were friends/housemates/drinking buddies although there are also references to them being in a partnership. Numerous call outs were made to the address by various agencies and the perpetrator had a

history of violence. The focus then has been on assessing whether agencies were adequately professionally inquisitive in order to assess vulnerability and risk robustly.

2.20 Other relevant factors (which can exacerbate abuse i.e. age, disability, sexuality) are:

- there was a significant age gap between the two men
- the victim and perpetrator had health issues, some of which were attributable to alcohol dependence
- both were alcohol dependent
- for the victim there may have been prohibitive factors about being open about his sexuality
- There may have been elements of exploitation of one party towards the other with elements of 'emotional leverage' exploited by the perpetrator for financial gain.

Chronology of Agency Involvement during Scoping Period (August 2010 to November 2012)

Please Note- the comments in bold *italic* font in the text boxes are made by the Author

2010

2.21 There is a significant antecedent history between Mr. E and Mr. Z stemming from around 2000. This sets the scene in terms of the violence and alcohol concerns for both Mr. E and Mr. Z and identifies the significant agency involvement, in particular from West Midlands Ambulance Service, West Midlands Police, Staffordshire Police, and the GP service.

2.22 In the summer of this year Mr. Z had extensive alcohol problems and sought support from the GP to cut down on his drinking, the GP made a referral to a Drug and Alcohol Services.

2011

2.23 In January 2011 Mr. E had made a visit to the Minor Injuries Unit (MIU) and is reported as being drunk, but not as having any other injuries.

2.24 In February Mr. E required medical attention as a result of alcohol withdrawal, ambulance services attended and found him to have vomited he was aggressive and refused the paramedic the opportunity to check his observations and asked them to leave; which they did. No follow up referral was made, and the chronology shows that the GP was not made aware of this incident.

2.25 Later this month GP records show that Mr. E attended the MIU with a wrist injury, a few days later he reported to the GP with hand pain. It is unclear how he had sustained the injury and there is no evidence that enquiries were made by hospital staff.

2.26 Mid-March Mr. Z had collapsed in the street, possibly due to Heroin (though Mr. Z denied this) and excessive alcohol use in Wolverhampton. As ambulance staff attended to him, he became aggressive and threatening; they called West Midlands Police. It was recorded that his aggression could be as a result of his seizures and no police action was taken against Mr. Z.

2.27 In March 2011 Mr. E attended Accident and Emergency (A & E), complaining of a fall and resulting pain to his right hand and wrist. hospital examination suggested that the injury was due to a punch; however, Mr. E left the hospital before any further examination or treatment could be given.

1. Mr. E attended the hospital on three occasions in 2011; though on one occasion doctors did not believe that the injuries were consistent with the explanation that they were given, no further enquiries or referral was made; this was a missed opportunity by the hospital to be professionally inquisitive.

2.28 The first reference (within the scope of this review) to a direct assault by Mr. Z on Mr. E took place during Spring of 2011. This was the first of several third-party reports of violence, as the caller is the brother of Mr. E. Staffordshire Police arrived to find that there was an argument between 'housemates' over a sandwich, resulting in one throwing a tray at the other causing minor injury to the face. The matter was not pursued by the police in line with the victim's wishes; the nature of their relationship was reported as 'friends'. It is noted that the victim Mr. E was under the influence of alcohol.

2.29 In May Mr. Z was admitted to A & E following a report of him having a fit, following no consumption of alcohol for two days; it was unclear who had reported this and whether it was at Mr. E's address. After ambulance staff assessed him, they took him to hospital. Whilst in A & E a number of tests were carried out including a CT scan and a chest X-ray, with no abnormalities noted, although it was reported that a further fit was observed whilst at A & E.

2.30 Mr. Z remained in hospital on the Acute Medical Ward (AMW), his demeanor was described as "wandering, aggressive and confused" and later he absconded from the ward. During this period of absence Mr. Z was sighted in the vicinity of a reported firearms issue, the police exercised caution due to this intelligence; he was detained by door staff and gave a false name, however police realised that his description matched that of the individual who had absconded from hospital and he was duly returned.

2.31 An assessment for mental capacity as carried out on Mr. Z's return to hospital and sedation was given with a recommendation that a mental health assessment be carried out when he was medically stable; this took place and he was deemed to have capacity. Mr. Z refused ongoing care and discharged himself.

2.32 Within twenty-four hours Mr. Z was readmitted to hospital with swelling to the arm, fever, and confusion as a result of sepsis. There was a wound to his left wrist with a septic discharge which he suggested happened as a result of a stanley knife injury a week prior, during a fight. Mr. Z was admitted to the AMW (Acute Medical Ward) for treatment with intravenous antibiotics. He agreed to stay in the hospital for a few days to receive treatment and detox from alcohol.

2.33 Mr. Z said that he lived with a friend and gave Mr. E's address. Mr. Z was seen by Liaison Psychiatry in the hospital and confirmed that on discharge he would return to the address in Cannock or go to his mother's home in Wolverhampton.

2.34 Mr. Z was discharged from hospital with outpatient follow-up for the screening of his liver function and blood tests. He attended neither of these appointments.

2. At this time both Mr. E and Mr. Z were struggling with health issues related to their excessive alcohol usage. Both had significant health concerns as a direct result of alcohol use and were engaged with health services, either as an in-patient or via GP services. It appears that Mr. Z's commitment to alcohol abstinence was temporary and appropriate follow up services were offered, however it is clear that both had rather chaotic lifestyles, often associated with historic drug and alcohol abuse and so Mr. Z did not pursue this any further. There is no record suggesting that alcohol support services were offered to Mr. E until 2012.

It also appears that alcohol consumption led to more risky behaviours and affected their ability to make the best health choices for themselves. The issue of mental capacity was briefly considered as part of the hospital stay for Mr. Z but ultimately, he was assessed as having capacity. The Mental Capacity Act would have been applied in the context of his ability to understand and accept the treatment offered to him in relation to this specific situation. So whilst Mr. Z would have been sober enough to understand what treatment was being offered to him one might argue that Mr. Z's priority was to access alcohol and not necessarily to receive treatment, which may have been the driver to leave the hospital.

Between 2011 and 2012 the GP had on record fourteen references to excessive alcohol misuse for Mr. E; however there was no record of referral for detox or discussion about alcohol withdrawal support services until October 2012 when Mr. E was offered a referral to the alcohol team, which he declined. There is nothing documented prior to this entry to indicate that Mr. E had been referred to Alcohol Therapy Services despite the multiple early signs of alcohol abuse.
The author notes that the GP did not identify these repeat incidents nor link them to any ongoing harm Mr. E may have been facing; this is also true of the other agencies involved with the victim, who eventually shared information in July 2012.
Mr. E had been registered with the same GP since 1987. As a result of this review the Chair asked that the GP records should be examined to see if basic information had been recorded or enquired about. Notably there is no reference on his medical records of a next of kin, sexuality, or marital status. It is the author's view that this information should have been enquired about and recorded even if declined, as a matter of course. This perhaps is a missed opportunity by the GP to be appropriately inquisitive about Mr. E and his domestic circumstances, from an agency that had significant and regular contact with the victim; especially since he was registered with the same GP practice since 1987.

2.35 During May GP records note a letter received regarding Mr. E and his attendance at Staffordshire Minor Injuries Unit with a wrist injury and a head injury.

2.36 In late May 2011 Mr. Z was admitted to hospital, due to having seizures and a hand injury. West Midlands Police were called by ambulance staff as Mr. Z was becoming aggressive; West Midlands Police attended but did not take any further action.

3. During 2011 and 2012 there are fourteen references to assault or injury in the GP records, (several of these are head injuries)
It is pertinent to reflect that during this period in GP records there is no documented reference to any discussion taking place with Mr. E as to whether he might be experiencing domestic abuse, or any exploration of how he had repeatedly sustained such injuries, this is a second missed opportunity for the GP to consider violence within his home and also opportunity to liaise with other professionals that may have had contact with Mr. E.

2.37 The following month Mr. Z required further medical attention when ambulance services were called to the home in Cannock; he was experiencing alcohol related convulsions and had hit his head. Mr. Z was admitted to Stafford hospital A & E and he advised staff that he had stopped drinking alcohol twenty-four hours previously. He identified that he had been having alcohol related convulsions for the previous three years.

2.38 Mr. Z had a repeat CT scan which identified no abnormalities; further discussion took place regarding an alcohol detox with a review planned for the following Monday, however, Mr. Z absconded from the hospital that day and returned to the home address, (Mr. E's address).

2.39 The hospital was concerned about Mr. Z though he had capacity, they asked West Midlands Police to do a 'Concern for safety' check on him. It materialized that Mr. Z had gone to an address in Cannock. West Midlands Police closed the enquiry.

2.40 The following day Staffordshire Police then undertook to do the welfare check and found him at a female neighbour's house (to Mr. E's address). Staffordshire Police ascertained that Mr. Z was "seeing" this woman (Ms. N) and that he did not want to return to hospital.

2.41 Days later, Mr. E reported an assault on him (cut to the head) by Mr. Z. Officers attended and reported that both Mr. E and Mr. Z lived together and that they were intoxicated; Officers were advised that the argument took place in the garden in the presence of the neighbour, who gave third party evidence stating that there had been **no** assault. After discussion with both parties it was agreed that no assault took place, it was an argument and one had apparently fallen in to the other.

4. This was the second alleged assault on Mr. E by Mr. Z. According to the chronology a cut to the head had been sustained. Staffordshire Police notes that the neighbour (Ms. N) confirmed that there had not been an assault.

Whilst police were in attendance it appears that Mr. E refused medical attention and so no ambulance was called. It is apparent that officers did not perceive any vulnerability issues despite this being a repeat call and having access to information relating to Mr. Z's violent history, no further action was taken.

Panel members identified that none of the agencies were able or had the right to prevent Mr. E and Mr. Z house sharing at this point.

2.42 On the following day Mr. E presented to the MIU with a head injury and was sent to A&E for further treatment.

2.43 Later that month Mr. Z had convulsions (reporting three that day) and required ambulance attendance. Ambulance records show that it was noted that the caller (Mr. E) and patient were intoxicated but neither were aggressive nor threatening on this occasion. Mr. Z was taken to Stafford hospital.

2.44 In July, Mr. E was taken to A&E by ambulance with reported blurred vision and a head injury. Records from the hospital showed that there were several abrasions to his face, a large laceration to the back of the head and a swollen lip, injuries considered to be consistent with an assault. Mr. E had no recollection of what happened but claimed to have been playing football. The injuries were not considered acute after a CT scan and Mr. E was discharged home.

5. It is recorded that the hospital identified injuries consistent with that of an assault, and NOT injuries sustained playing football, however no further enquiries were made with Mr. E. Had the victim been a woman attending A & E it is more likely that given the domestic abuse training offered to A & E staff, health professionals might have pursued a more detailed line of enquiry if the injuries were of a suspicious nature. If any detailed questioning took place by the medical practitioner on this occasion it is not recorded on the case notes and in any event no further action was pursued as a result.

The IDVA advisor to the panel suggested that irrespective of Mr. E's sexuality as a man he may well have been less likely to have been questioned about his injuries due to commonly held perceptions around masculinity and issues around physical abuse in a domestic setting may not have been explored with him as a man, as the 'norm' might have been a female victim and a male perpetrator.

2.45 Five days later there was another third-party call to the police from Mr. E's brother stating that Mr. E was being assaulted by his partner, and named Mr. Z as the offender; six out of the ten third party calls made by his brother to the police made reference to Mr. Z being Mr. E's partner.

On this occasion Staffordshire Police made simultaneous telephone contact and a visit to Mr. E; he reported his partner Mr. Z had assaulted him (for the second time) the previous week causing a head injury. It was reported that the offender was now out of the house; Staffordshire Police updated their records to say that it was not a domestic incident nor an assault but two friends having an argument.

6. This is a significant missed opportunity by Staffordshire Police to have identified that there may have been more to this relationship than just an argument between two friends. The allegation of a head injury is consistent with the previous incident and is consistent with the hospital assessment that the injuries were caused by an assault rather than playing football.

It is also pertinent that the caller identified Mr. Z as Mr. E's partner and that Mr. E himself said the same on this occasion.

Mr. E's brother suggested that this was not the first time Mr. E had been assaulted by his partner and that Mr. E had attended hospital on numerous occasions as a result of injury inflicted by Mr. Z.

Staffordshire Police did not identify Mr. E as being vulnerable, nor were steps taken to speak to his brother to help to identify potential risks to Mr. E or Mr. Z. They did not follow up contact from his brother nor was it recognised that Mr. E was vulnerable to being repeatedly victimised by Mr. Z (a known violent offender). This was a missed opportunity to provide appropriate support and assess vulnerability and risk effectively.

Agencies might reflect that it is plausible that officers too readily accepted that there was no assault, did not make further enquiries about the nature of the relationship or at the very least accepted at face

value that they were friends or housemates, though some police officers when interviewed recalled that there was a same sex couple living at the address and that one or both of them were alcoholics, though the attending officers were told on more than one occasion that they were just friends and this was accepted as true. I have referenced earlier on in the report some of the challenges that gay men may experience in disclosing their sexuality; it may also be true that officers were less aware about how to deal with same sex relationships at that time.

It is noted that a clear allegation of domestic abuse was made by Mr. E's brother and corroborated by Mr. E himself; Staffordshire Police officers accepted a view that they were just friends and no further action was taken. The officers may have too readily accepted that they were friends rather than partners; there was an allegation of violence and indeed confirmation on this occasion that an assault had occurred the previous week and the two who were living in the same household, this is a missed opportunity. There are some risk factors which should have highlighted vulnerability or potential abuse within a domestic setting which officers might reasonably have been concerned about and sought to liaise with other partner agencies to see if there was any further information or indeed any further risk factors in this case, however this did not happen.

Though hindsight should be used with caution, it is very possible that this might have been seen in a different light had it been a heterosexual couple and I doubt that officers would have been so readily accepting that it was simply a disagreement between friends. This demonstrates a lack of training and awareness around same sex domestic relationships and also identification of vulnerability, resulting in an inadequate service.

This is the first <u>significant</u> incident where opportunities to seek further information were missed.

2.46 At the end of August there was another call out for an ambulance to attend a man having convulsions at the home address. Ambulance crew arrived to find Mr. E pale and clammy. Mr. E advised ambulance staff that he had several fits in the last hour and that he consumed a litre of cider the previous night. Mr. E became physically and verbally aggressive and refused further assessment and was taken to A & E.

2.47 On assessment by medics at Stafford Hospital A & E Mr. E admitted to drinking forty units a week for the previous six months. A number of tests were carried out, but no acute injury was found, though he was treated for a chest infection and medication for alcohol withdrawal was also administered.

2.48 Mr. E had been hospitalised for several days but left the hospital without notifying the staff; Staffordshire Police were informed by the Hospital but as part of this review police found no record of this referral.

2.49 Mr. E attended the MIU with a painful wrist injury in September, the following day Mr. E's brother reported that Mr. E was being assaulted and contacted Staffordshire Police, the initial call type was recorded as a domestic abuse

incident. Police arrived and judged that there had been a verbal argument and that no one had been assaulted, no one had any visible injuries and Mr. Z was asked to leave the property.

2.50 The police recorded that Mr. E's brother identified Mr. E as disabled and police call handlers sought assurance that there were no children in the home; this is in line with standard Staffordshire Police safeguarding policy. On visiting the property observations were made that no signs of disturbance were evidenced.

7. The matter was finalised as a non-crime domestic issue; officers made a judgment that there was no crime committed, no visible injury was noted, and there was no intimate relationship. Staffordshire Police should have clarified the nature of the relationship, in line with allegations around domestic abuse, Mr. E and Mr. Z should have been spoken to separately. There is no evidence that this happened. There is also no reference to any follow up action with agencies to assess wider vulnerabilities, given that there had been numerous call outs to this address involving violence. No contact is made with Mr. E's brother as the third party who reported the incident, and this is a second missed opportunity by the police to ascertain more information and consider what the risks were. On several occasions' officers spoke to the two individuals whilst they were under the influence of alcohol and did not consider following up contact when they were sober, nor did they seek to liaise with or refer to any other partner agencies.

2.51 During October there was a call out to a domestic incident to attend Mr. E's neighbour's address, the call was made by a female and the perpetrator identified as Mr. Z, the female said that she could not get out of the house and there was shouting to be heard from a male voice in the background (according to Staffordshire Police records) and to get there as quickly as they could. There were threats to smash the house up and there was arguing between Mr. Z and the female.

8. It is unclear if Mr. Z's relationship with Ms. N was ever problematic beyond this incident. There is no evidence to suggest that Staffordshire Police considered if this woman was at risk due to Mr. Z's violent past. This should have been an opportunity for the police to consider the situation as domestic abuse given that Staffordshire Police had records identifying Mr. Z as "seeing" this woman and having a violent history. Police records show that the initial call type was domestic abuse and that the question sets used to assess risk and vulnerability were exited before completion, though officers attended quickly. This is poor practice when attending a domestic situation, the officers simply accepted that there was no crime incident.

Safeguarding considerations were not made or taken following this incident, the depth and breadth of Mr. Z's previous violence was not explored and therefore not evaluated and the risk he posed to others was not considered, this demonstrates a lack of awareness around vulnerability and risks of a violent offender.

2.52 Staffordshire Police officers attended the incident and updated that there was no domestic assault, but a drunken disturbance between friends, this was the female complainant (recorded as ex-partner from the initial call) however no crime was recorded, no further action was taken and no referral or risk assessment made.

9. Neither the female partner Ms. N, or Mr. Z was known to the Staffordshire Police internal intelligence system, more thorough/ wider checks might have identified previous crime reports on PNC etc, this is of concern as Mr. Z had a significant previous history of violence particularly towards women which is well recorded within the West Midlands Police Service. This is the third missed opportunity by Staffordshire Police to identify the risks that Mr. Z posed to others.

2.53 Almost a month later there was a further call out for a domestic incident, the victim being Mr. E, the alleged perpetrator being Mr. Z, reported by the victim's brother. Mr. E contacted his brother and told him he was being attacked. The police checked previous calls and officers were dispatched to the home address.

2.54 The officers concluded that there was a verbal dispute between the friends over a bottle of cider, both were alcoholics and under the influence of alcohol. The police took action and removed Mr. Z from the address.

2012

Notably there was no recorded contact with any agencies from November 2011 up until February 2012 for either Mr. E or Mr. Z and the review could not find any reason for this.

2.55 In February, Staffordshire Police were called once again by Mr. E's brother, alleging violence against Mr. E from his partner (this being Mr. Z). The caller told police control that the attack was happening at the time of the call and requested urgent attendance; the brother advised control room staff that his brother had asked him not to call the police.

10. It is possible that Mr. E was fearful of reprisal from Mr. Z if the police were called, or due to the co-dependent nature of their relationship he did not want to 'lose' him; ***either way there appears to be an element of control in the relationship; this situation is compounded by the fact that both parties were regularly under the influence of alcohol. It must be acknowledged that it would be difficult for responding officers to decipher the truth of an assault whilst both parties were heavily intoxicated; however, it would have been entirely appropriate to consider referral to other agencies. It seems that police officers missed opportunities to make referrals to other agencies who might have advised Mr. E of support available whilst he was sober, furthermore it appears that information relating to repeat calls to Mr. E's address were not linked up with previous call outs.***

2.56 Staffordshire Police records indicated that there had been a verbal altercation between tenant and landlord officers had concluded that the

incident was not a Domestic and that the parties concerned were not and never had been in a relationship. The police took action by removing Mr. Z from the property and escorting him to his mother's house in Wolverhampton.

11. It is important to note that there could have been better interrogation of intelligence systems by the police to assess risk better. However, on this sole occasion contact was made with the Mr. E's brother, who accepted the outcome.

It appears that the general impression held by agencies was of two drunken men/ friends, with the root cause of the injuries being related to heavy drinking and no more than that. This was a somewhat superficial position to take given that there was a lack of professional inquisitiveness from agencies about the domestic setting, Mr. E being gay and the number of call outs to the police made to the address for violence (sixteen calls for service from April 2011-August 2012)

2.57 In spring 2012 Mr. Z. was arrested for an assault in Wolverhampton City Centre. The victim was Mr. E. who had suffered a head wound.

12. During this investigation West Midlands Police were aware that Mr. Z and Mr. E were known to each other for the previous six years, and that they lived together from time to time.

As there was no indication of Mr. Z and Mr. E being in a relationship, no DA safeguarding risk assessment was completed. Officers became aware that Mr. E and Mr. Z lived together, but there is no record to suggest that it was ever considered that they were in any form of "intimate relationship". There was therefore no requirement to engage in domestic abuse related safeguarding or domestic abuse recording.

There were records that two previous assaults were carried out on Mr. E by Mr. Z one in June 2004 and the other in July 2005, however neither led to a prosecution as the victim would not cooperate. There should have been greater consideration of the risk Mr. Z posed to Mr. E even though there was no correlation with the DA policy. This is the fourth missed opportunity for agencies to liaise with each other to share information and consider the extent of risk that Mr. Z posed to Mr. E.

2.58 On 28th March a police officer from West Midlands Police visited Mr. E after seeking a 'log reference' from Staffordshire Police in order to take a statement.

13. There is no further information available about this contact, i.e. was there any discussion about the nature of the relationship, was Mr. E alone or were others present, was he under the influence of alcohol? This shows poor record keeping.

2.59 In early April 2012 Mr. Z was arrested for a separate matter involving being drunk in public place; simultaneously there was a warrant issued at Wolverhampton Magistrates Court for his arrest, for failing to attend court in relation to the assault.

2.60 On this occasion there was a successful prosecution by West Midlands Police; Mr. Z was convicted for assault (occasioning actual bodily harm). He pleaded guilty and was given four months imprisonment suspended for eighteen months with supervision by probation and attendance of an accredited Offender Alcohol Abuse Programme (OAAP).

The probation service assessed Mr. Z as a medium risk to Mr. E and initiated work with Mr. Z.

14. At the point that the probation service became involved with Mr. Z, there were several significant missed opportunities identified at the outset though once under the order the probation service appropriately discharged enforcement. The order however was based on incomplete information, with no record of previous convictions within the standard delivery report. It appears that the probation officer (PO) conducted the interview via video link and more importantly had not had sight of the CPS documents as they had been sent to the wrong address. Consequently, there was no information about Mr. Z's previous violence nor were attempts made by the PO to have direct dialogue with either West Midlands or Staffordshire Police about the number Mr. Z's violent history or any concerns about where he was living.

This is the first <u>significant</u> missed opportunity by the probation service to have dialogue with either of the police forces despite protocols being in place.

This means that decisions were made on incomplete information, specifically the Standard Delivery Report did not contain information about Mr. Z and his previous violence, nor did it capture whether Mr. E had been a victim before nor was an alcohol screen completed, which was a significantly aggravating factor in this case.

This failure caused an important error in identifying the genuine risk that Mr. Z posed to Mr. E. In 2017 this information is all downloadable electronically and therefore the risks of a similar situation arising less.

2.61 On 1st May Mr. Z attended the probation service office and set his goals with the probation officer, to stop drinking alcohol, to find his own accommodation and to find some employment. A referral was also made to local addiction services.

2.62 On 2nd May three telephone call were made by Mr. E to Staffordshire Police alleging that Mr. Z was threatening to kill him, the call taker identified that Mr. E had slurred speech and was shouting "get him out of my house." Mr. E was heard shouting "He is a nut, I am covered in bruises, he deserves what he is going to get".

2.63 According to Staffordshire Police records it is made clear to the call taker that Mr. Z was on probation, Mr. Z asks police to attend to remove Mr. E before he violently assaults him".

2.64 Police attended this incident and recorded it as a verbal disagreement between two alcoholics and that both "had had too much to drink and were possible alcoholics, but both were calm and happy to remain at the address".

15. A month after the violent assault against Mr. E police are called to his address regarding threatening behaviour from the same perpetrator. The Police were aware that both were residing in the same house; that Mr. Z was on some sort of licence (technically a Suspended Sentence Order (SSO) and that threatening behaviour was alleged. However, no background checks were carried out nor was contact made with the probation service.

This is the fifth missed opportunity by police to gather intelligence and liaise with other partnership agencies to assess vulnerability and risk.

West Midlands Police had information relating to Mr. Z's violent past and had helped convict Mr. Z of the offence against Mr. E in April 2012, they continued to have contact with him up until mid-May, 2012, (where he was alleged to have assaulted his mother).

The probation service were engaged with Mr. Z and were aware of risks associated with the relationship between Mr. E and Mr. Z, yet none of these agencies communicated with one another, a golden opportunity to share information and assess risk robustly, this is a significant period of time in this situation when criminal justice partners failed to communicate with each other.

2.65 The following day Mr. E went to the MIU to receive treatment for a head wound, which required gluing.

2.66 On 8th May 2012 the police were called once again to the home address, on this occasion the report came from a third party, Mr. E's sister reporting that there was an aggressive male at her brother's address and he was refusing to leave the property, Mr. Z was named as the offender.

2.67 The police attended, and Mr. Z was removed from the property and escorted to his mother's address in Wolverhampton. Police took additional action of a fourteen-day tag for Staffordshire Police to follow up.

16. A second call to the same address within a week, whilst the Police took action by removing Mr. Z, this incident was not shared with the probation service.

Given the extent of information shared with the Staffordshire Police they should have followed this up with the probation service as a matter of course, but they did not. If they had, perhaps there could have been an opportunity to change the supervision order to protect repeat victimisation of Mr. E.

Notably this call was registered as one of antisocial behaviour. Mr. E was recorded as a repeat victim of anti-social behaviour.

As no information was shared about this incident there were opportunities missed to signpost and possibly to make appropriate referrals to other agencies. Furthermore, agencies would have been alerted to the fact the Mr. E was at heightened risk due to his ongoing contact with Mr. Z.

2.68 A few days later, Mr. Z visited the probation office to see his probation officer. He made no report of the incidents a few days earlier, the probation

service had no record of those incidents at this time and no contact had been made by Staffordshire Police advising the probation service of the police call outs to the address.

2.69 On 14th May the probation service completed an Initial Sentence Plan (ISP), they identified there were no notes on file relating to pre-convictions or a formal alcohol audit. These should have been completed as a matter of course for the court hearing in April 2012 but were not. This was on account that the CPS documents were sent to the wrong address at the time of the standard delivery report being compiled.

17. Agencies, in particular probation, were asked to explore whether this was a systemic failure or a single incident. The probation service should consider their practice and reflect on whether this was effective practice. I consider that there were significant and meaningful gaps in the practice of the probation service in dealing with Mr. Z and his risk to Mr. E.

It is recorded that Mr. Z was at medium risk of harm to others which included Mr. E specifically named as being at risk within a few days of the initial assessment there was confirmation that Mr. Z was living with Mr. E i.e. the victim of the assault. Had this situation related to a woman there might have been more robust protective measures put in place; the nature of the relationship between Mr. Z and Mr. E was still unclear to the probation service, and it would have been appropriate to find this out once Mr. Z was a NPS client. At this stage previous convictions would have been available; opportunities to be proactive and seek more details at initial assessment would have been needed to ensure that both risk and repeat victimisation were robustly considered. This is a second significant missed opportunity by the probation service. The probation IMR. notes "the mistakes at report stage are repeated at assessment stage and there is no triangulation of information by speaking to partners to properly assess risk and opportunities to reduce repeat victimisation."

2.70 Mid May 2012, Mr. Z visited his probation officer (PO) who confirmed with him that he was living with Mr. E (the victim of the offence he had been sentenced for). Mr. Z had no recollection of the visit he had made the previous week to the probation service and the PO noted that Mr. Z. was visibly shaking but not under the influence of alcohol. The PO advised Mr. Z that she would be contacting Mr. E.

18. It is of significant concern that once the facts had been established around Mr. Z's violent past and addictions, no dialogue took place between probation, police and the GP to establish clear facts and the levels of risk associated with Mr. Z and Mr. E. This is the third <u>significant</u> missed opportunity by the probation service to share information and assess risk and vulnerability of repeat victimisation. Even though there was vague and conflicting information about the nature of the relationship between Mr. Z and Mr. E, agencies missed this opportunity to accurately risk assess the situation and the individuals concerned.

It is clear that there was insufficient follow-up and connection with partner agencies and this was a significant missed opportunity for the probation service to have engaged in robust partner dialogue to ensure that appropriate risk assessments and pooling of information between agencies was taking place, this might have led to proactive effort to engage with Mr. E as the victim.

2.71 Mid May 2012 West Midlands Police were called to Mr. Z's mother's address regarding an assault on her. After consideration and discussion with the victim West Midlands Police officers agreed that no further action would be taken, they had established that it was a verbal argument between Mr. Z and his step father and his mother tried to intervene, receiving a slap to the side of her face, causing momentary pain. West Midlands Police recorded the offence as a common assault, and it resulted in a Community Resolution. The policy at that time stated, "in a small number of cases the use of Community resolution may be appropriate, cautions and Community resolutions are rarely appropriate in domestic abuse offences but are preferable to no further action". The domestic abuse policy which was written in 2005 was in operation at the time of this incident, where officers were encouraged to take 'positive action' and that cautions were preferable to no further action being taken.

19. There were opportunities for West Midlands Police to have shared this information with other agencies, as they had access to information relating to his previous and current convictions, however no contact was made with probation or Staffordshire Police, this is a missed opportunity. West Midlands Police were aware that Mr. Z would leave his mother's address and go back to the address in Cannock i.e. the home of his recent victim of assault. Officers should have taken this opportunity to clarify if this was appropriate; this did not happen and is evidence of lack of information sharing with partners.

2.72 On another visit to his probation officer, Mr. Z said he had stopped drinking the previous day and was keen to enter into a detox programme, he was referred to ADSIS (Alcohol Support Services)

2.73 On the same day Mr. Z was seen by the practice nurse at his GP surgery, it was recorded that he was consuming ninety units of alcohol a week and twenty cigarettes a day. He mentioned that he had a referral to ADSIS and the GP made a referral to an alcohol detox centre.

2.74 Over the next few days there was contact between the probation officer and Mr. Z to progress both the debt issues and the referrals for detox.

2.75 At the end of May both Mr. E and Mr. Z attended different hospitals separately; Mr. E for an x-ray for a wrist injury and Mr. Z to have a dressing replaced from a punch injury.

2.76 The probation service sent a letter to Mr. Z at the end of May advising him of a referral for alcohol support services with a date to attend an open session. On the same day Mr. Z attended the probation service to meet his PO and they discussed a number of things, including the above referral. Notably on this visit the PO challenged Mr. Z about a punch injury to his hand, showing some professional curiosity; Mr. Z advised that he had hit a wall during an argument with his stepfather. He disclosed that he had been taken to the police cells and was later released.

20. Mr. Z is likely to be referring to an injury which took place over two weeks previously with his step-father; WMP agreed a community resolution with the parties involved, there was no other recent record of an altercation with his step father, where he was arrested and taken to the custody suite.

The author considers this an appropriate time for the PO to seek contact with West Midlands and Staffordshire Police to elicit further details and corroborate (or otherwise) Mr. Z's story; this did not happen, and is the fourth <u>significant</u> missed opportunity by the probation service to share information with other agencies.

2.77 On 30th May 2012 Mr H attended his meeting at the Probation Service. The PO involved in the case made a telephone call to Mr E to find out more information about the living arrangements. Mr E stated he was happy to allow Mr H to continue to live with him at his home, and that there had been no further incidents.

21. Whilst the PO took a proactive approach in clarifying the position of the victim in relation to their service user (Mr. Z) this did not go quite far enough to protect future victimisation. This is yet another element of a missed opportunity by the probation service to liaise with the police and other agencies to confirm if indeed what they had been told was true and to assure themselves that there had been no further or previous incidents in relation to Mr. E. A more robust curious approach would have evidenced that there were potential concerns for the safety of the victim, which could have led to further appropriate risk assessments. This was an opportunity missed to corroborate and secure all relevant information about the situation which might have helped professionals to better assess risk.

Mr. Z attended the probation service the following day where in theory at least there were opportunities to cross reference and check any information received from Mr. E with Mr. Z. This did not happen.

It must be noted that Mr. E was not open and honest with information at times and this made it difficult to engage and understand the true

extent of the violence. Family members commented that this was often "to protect Mr. Z".

2.78 In early June Mr. Z failed to attend an appointment with the probation officer, a Warning letter was sent to Mr. Z with a date for a future appointment.

2.79 On 9th June, Mr. Z had a punch injury to his right hand and was referred to the A & E department but did not attend.

2.80 Over the following few days, referrals to the alcohol team and a self-assessment form were sent out to Mr. Z to progress the support offered to him.

22. There was a significant difference between the number of Units of alcohol Mr. Z advised the practice nurse in May 2012 (ninety units) and the number of units he admitted to with the probation officer (four hundred units). Though his does not make a material difference given Mr. Z's alcohol dependency this could be a symptom of the chaotic behaviour often associated with addictions or a glimpse into the truth about Mr. Z's drinking habits. This could be an indication that the drinking was 'getting out of hand', or on the verge of breaking point for Mr. Z. There is also some correlation with the severity and number of assaults Mr. E faced between May and July 2012.

2.81 By mid-June 2012 Mr. Z was invited to attend his appointment with the probation service, where it was stated that Mr. Z had not completed his alcohol diary, (estimated four hundred units of alcohol per week), nor had he pursued the contact at the fines court.

2.82 Soon afterwards ADSIS received a completed alcohol consumption self-assessment form to initiate therapeutic work with Mr. Z.

2.83 On 21st June Mr. Z met with his probation officer and advised her that he had completed the alcohol self-assessment paperwork for the community alcohol team, but that he had not made it to an open session at ADSIS as he had to attend the hospital with Mr. E due to him having convulsions.

2.84 On 3rd July 2012 whilst Mr. E was out, a passer-by noticed Mr. E had blood coming from his head and called the police; a patrol was duly dispatched to Mr. E's home, where he was unable to tell them what had happened as he was heavily intoxicated. It was noted that two males lived at the address and that the other male was Mr. Z, though he was not present at the time and Staffordshire Police carried out a PNC check. An ambulance was called to the home address, on arrival the ambulance service confirmed that Mr. E had a head injury, it appeared that he had a cut to the head. Mr. E was taken to A & E, after examination there was no acute injury, he was transferred to the Surgical Assessment Unit (SAU) for the cut on his head. However, Mr. E absconded from the hospital with his cannula still in place. The hospital called the police.

2.85 On 7th July 2012 a nurse made a safeguarding referral to the emergency duty team. Mr E had disclosed that Mr Z had assaulted him and that they lived in the same household. Social services identify this referral **NOT** as a safeguarding referral, but an assessment for care needs.

23. This is the first of the referrals to EDT and the referral fax records "Gentleman is alcohol dependent...violence in household from a friend that lives there"

It is noted that this is effective practice from the hospital in identifying concerns and taking action, it is also noted that the referral is responded to by social services in a timely way.

However, the concern with this referral is that it <u>should</u> have been considered as a safeguarding referral and reported into the MASH (Multi-agency Safeguarding Hub). The referral fax clearly references that Mr. E is in fear of Mr. Z, that when they have both had a drink Mr. Z attacks him and causes injuries that require treatment; it also reports Mr. E "always refuses to press charges as he feels the attacker will come back and attack him; the attacker goes away when the police are involved but always returns to the house".

The sister/nurse who is the referrer of the case details the issues clearly and makes an entirely appropriate referral which is good practice. The MASH might have considered the threat, harm and risk to Mr. E rather than an assessment of care needs.

2.86 A telephone call was made to Mr. E by a Duty social worker on 9th July to offer him a care assessment; it was declined.

24. The social worker records the telephone call, outlining the reason for the call and noted that when asked if Mr. Z was present Mr. E said he was not. Records show "Mr. E declined a visit or support.". The social worker left contact details.

Mr. E did not pursue the offer for help, but it was not specific in the notes as to what kind of support was offered.

The response from social services lacks professional curiosity and detail regarding the specific support that might have been offered. This is a missed opportunity by social services. There was no further follow up from this discussion and no other agencies were contacted to share information.

2.87 On 16th July 2012 a second opportunity presented itself, Mr. E attended the MIU and disclosed that he felt threatened by Mr. Z, that they were living at the same address and that there was a history of violence. A second referral was made to EDT (Safeguarding referral) where the case was allocated to Staffordshire Adult Protection Investigation Team; this resulted in the completion of a multi-agency information sharing document which was completed by the 19th July 2012.

25. As a result of these two referrals, telephone contact was made by a social worker with Mr. E in order to assess his needs during July and August 2012, there were concerns for his welfare but he continued to be unwilling to engage with services. It is of note that there are incomplete social services records of contact from 20th July to 15th August 2012; thus the detail of what was offered is not reflected in the case, this is poor record keeping. It is imperative that case notes

accurately record information and discussion in order to safeguard professionals and maintain standards and accountability.

2.88 On 19th July 2012, adult social services tried to make telephone contact with Mr. E but to no avail. Social services initiated a series of calls/discussions with probation, police, NHS bodies (including GP, Alcohol Services, A & E) as part of the MASH (multi agency safeguarding hub) in order to complete a multi-agency information sharing document (MISSD)

26. It should be noted that the collation of information at this stage is effective practice and there is evidence on the MISDD that there is a high risk to Mr. E, it records that Mr. E is afraid of Mr. Z (housemate); that Mr. E has presented thirty-nine times in the last two years to the MIU; it records that the police were called to the property eleven times between April 2011 and July 2012 to alcohol related incidents, with possible domestic violence and high number of presentations to hospital with five possible head injury assaults. It is decided that this is a single agency investigation.

2.89 On 20th July four calls were made to Staffordshire Police between approximately 2200 hrs and 2300 hrs; the first was from Cannock Hospital reporting a concern for safety as Mr. E had left the hospital without being properly assessed for a head injury; the second was a call from a resident reporting a domestic disturbance and the third and fourth were from Mr. E's brother reporting an assault on his brother. The police responded and attended the address, there was no sign of injury and both Mr. Z and Mr. E were heavily under the influence of drink. No follow up action was taken.

2.90 On 23rd July Mr. Z had an appointment with the probation service and disclosed that Mr. E was hospitalised a week earlier but that he did not injure him.

26. The probation service missed opportunities to cross check the information given about Mr. E being hospitalised with other agencies given that the risk of harm was acknowledged as high a week earlier during agencies discussions. This is fifth significant missed opportunity by probation services to reassess risk and generate dialogue with other agencies and Mr. E himself.

2.91 Around this time in July Mr. Z visited his GP for a twenty-eight-day medical certificate and informed his GP that he was attending probation support and awaiting detox.

2.92 On 1st August social services and probation discussed that there had been numerous call outs to Mr E, that he had sustained injuries on several occasions, but that invariably Mr E was reluctant to cooperate with agencies. A MAPPA (Multi Agency Public Protection Agency referral was considered but deemed inappropriate as Mr Z did not meet the criteria of having a custodial sentence.

2.93 On 2nd August the Social worker agreed to carry out a visit to encourage Mr. E to take up support.

27. This is a good approach from the social worker, to make face to face contact to encourage Mr. E to engage, but this too was unsuccessful. Though there is a protocol for client non-engagement, the Policy applies where an assessment for need has been made and offered and has not been taken up, this was not the case here as Mr. E was deemed <u>not</u> to have care needs in accordance with adult social care frameworks.

2.94 During the first week of August the police received a call out to an assault, reported by Mr. E's brother, stating that Mr. E had been attacked by his partner. On arrival the police found that there was one male present (Mr. Z) he was drunk. Contact was made with the victim (Mr. E) and it was established that he was at the Minor Injuries Unit. A heavily drunk Mr. E stated that he had been kicked and punched in the head. The officer spoke to the nursing staff and established that there was a graze to Mr. E's head but that further treatment was not required. The police followed up with attendance at the hospital, but Mr. E had left, they patrolled the area in an attempt to find him and eventually located him at home. Mr. E stated he did not have any recollection of the incident and could not confirm what had taken place. He was given advice by the police officer which included that he should consider getting Mr. Z moved out of the house and to contact Staffordshire Police in the event of further problems.

2.95 On 7th August 2012, Mr. E and Mr. Z visited the probation service; an appointment to discuss alternative housing for Mr. Z was made for 10th August. During this conversation the probation officer persuaded Mr. E to accept some support; as a result, he was willing for a home visit to be carried out. The probation officer made contact with the social worker to advise of this and a visit was arranged for 21st August 2012.

28. The police intervention was sound and encouraged the victim to raise concerns via the police.

This is good practice from the probation officer; immediate follow up once Mr. E agreed to support. It is unclear if Mr. Z was present during this conversation or whether there had been any clarification of the nature of their relationship. In any event the PO should have seen them separately to discuss the issues. This would have been best practice. However, the author notes that this is a genuine opportunity for engagement with Mr. E.

2.96 The alcohol team sent a letter inviting Mr. Z to an appointment drop-in session on 8th August.

2.97 On 10th August Mr. Z visited the probation service and options regarding hostel placement were discussed with him, though Mr. Z was reluctant to move to a hostel.

29. Note: Mr. Z may have put Mr. E under pressure to continue to offer him a place to stay; on speaking to the family their view was that Mr. E wanted him to be around but that they considered Mr. Z to be exploiting Mr. E's good nature. Mr. Z advised that Mr. E was a good friend and that he had "really helped him out".

Mr. E may have been reluctant out of fear, to receive support from outside agencies. Certainly, views expressed from the family suggest that Mr. E did not want to discuss things openly and sometimes 'downplayed injuries that Mr. Z gave him', sometimes saying that "he had fallen or banged into a cupboard". Agencies did not explore this element of their relationship as the nature of their relationship was often referred to as being 'house mates' or friends and consequently domestic abuse and vulnerability risk assessments were not considered or undertaken. This highlights the importance of professionals demonstrating professional curiosity, cross checking information for factual correctness etc.

2.98 On 13th August Mr. E visited the hospital for a follow up MRI scan following a previous head injury.

2.99 On 15th August a social worker contacted Mr. E by telephone to discuss support, but he declined any support, stating that he did not want anything to change in respect of Mr. Z. Social services planned a home visit, nonetheless.

2.100 Mr. Z missed the appointment with the Community alcohol team on 17th August. Mr. E visited his GP and identified memory problems and poor visual perception. The GP commented that if symptoms persisted then a memory test might need to be conducted.

30. Whilst it was good practice for the GP to have identified the need for a memory test, this is not pursued further; Mr. E had had several head injuries and was a heavy alcohol user. It would have been appropriate to refer him for a memory test at this point rather than delay matters further.

This is especially important from the perspective of this review in that there is general consensus that Mr. E had full capacity. It is possible that this may be questionable given his symptoms but also his addiction to alcohol; this is a missed opportunity to offer appropriate support and assessment by the GP.

2.101 Mid-August 2012 it is reported that the police were called by Mr. E's brother, to an assault at the home address. Mr. E was contacted via telephone, he sounded heavily intoxicated. He stated that Mr. Z was not at the address and indicated that he was not supportive of making a complaint of assault.

2.102 Officers attended anyway and found Mr. Z to be there; they spoke to both parties, they identified that no assaults had taken place; both Mr. Z and Mr. E were under the influence of alcohol. Mr. E was found asleep and had no recollection of what had happened; he had fallen back asleep by the time the police officers had left. The police concluded that the incident was a no crime domestic, a verbal disagreement and nobody had a visible injury, no DIAL

form was completed, and this was in line with the discretionary policy operating at that time (now it is mandatory).

2.103 On 19th August the ambulance service received a call from an intoxicated male saying that he had assaulted somebody with a punch, the call handler spoke to the patient and was told that an ambulance was not needed. The ambulance service notified the police and asked them to attend. The police attended and found both Mr. Z and Mr. E to be under the influence of alcohol but notably no one had been assaulted; one officer recalls asking them specifically if they were in a relationship, Mr. Z stated they were not in a relationship but that he was homeless and was staying at the address.

2.104 A further call was received by the ambulance service some twenty minutes later from the same address, suggesting that Mr. Z was unconscious. A vehicle was dispatched, a dialogue between the ambulance service and the police took place and the police advised that they would not attend again, they recorded this as a hoax. The patient was identified as Mr. Z and he refused transport to the hospital.

31. The victim of the assault was Mr. E and the police attended initially but believed that no assault had taken place; both males were heavily intoxicated and laughing.

It is difficult to gauge exactly what had happened on this occasion, and the police believe the call to be a hoax, and neither party was injured. Under the circumstances it seems reasonable for Staffordshire Police to have established that no one was injured, identified both were intoxicated and decided that a further call out to the address was not warranted. Mr. E is not identified as being at risk in any way.

2.104 The social work team visited Mr. E and Mr. Z on 21st August 2012 but were declined entry into the home. A doorstep conversation took place with Mr. E and Mr. Z; social services then contacted the probation service and the police to advise them that support had been declined.

32. Following the visit of 21st August, a sequence of telephone calls were made involving a few key agencies (social services (adults), probation and Staffordshire Police). Social services records suggest the following areas were discussed between agencies: ascertaining whether Mr. E was receptive to support from police or social services, whether he would accept support with his alcohol dependence, consider whether he wished to pursue domestic complaints with the police; identify whether housing support might be offered or police support, referral to other agencies with agreement from Mr. E, links were to be made with GP, but no formal contact took place and there is no evidence of any input from GP services.

It is reported that during a telephone conversation between social worker A and a probation officer she suggested that there was nothing that could stop Mr. E from allowing Mr. Z to live with him, despite the risks to him there were no conditions attached to the Community Order which might prohibit Mr. Z from living with Mr. E. Reference is made to the situation being "no different to a woman being subjected to

domestic violence, and letting her partner remain at the same address". This commentary may be perceived as judgmental and there is no acknowledgement of the shortfalls in the original reports for the courts.

The social worker also makes contact with the police and ascertained that "there have been seventeen logs between 02.04.2011 and 03.07.2012"

The outcome of these discussions was that Mr. E was deemed to have capacity and only needed alcohol detox, a letter advising him of support services for this was sent to him; with "relevant contact numbers if he wants support from alcohol services or the police"

At no point is there reference to the range of issues discussed between agencies mentioned above, being discussed with Mr. E himself. There is no recognition that Mr. E is a gay man, references to agencies are almost always that they are housemates living together. The author notes that it is not unusual for victims of domestic abuse to refuse services, or feel concerned about contact from agencies, particularly if the perpetrator is present. It seems that efforts to discuss the real danger Mr. E was in were superficial this was compounded by the fact that he was often under the influence of alcohol. However, it is custom and practice for DA workers to explain risks and vulnerabilities to victims, so that they can make a choice as to what action they might take. Mr. E was not afforded this opportunity.

33 The author questions the usefulness of the letter to Mr. E, knowing that agencies were under the impression that Mr. E would refuse services. The fundamental issue here is that no agency took the view that someone should explain the potential danger he Mr. E was facing in continuing to liaise with Mr. Z, of course this does not mean that Mr. E would have taken up any support but it is of concern that in circumstances such as these there was an absence of dialogue with Mr. E when he was sober, notably there was family support around for Mr. E who might have been enlisted to outline the kind of support that might be available to him. Indeed, on speaking to Mr. E's brother, he suggested that he had felt as if he had made a nuisance of himself with the police in order to try and help protect his brother from further violence.

34. Whilst it is effective partnership practice to liaise with other agencies, demonstrating some communication links between the social services and probation and police, there appears to be an acceptance that there was nothing more to be done in this case; there was a general consensus amongst those involved that there was little that could be done to enforce separate living arrangements for Mr. E and Mr. Z, though several agencies are on record as recognising some sort of vulnerability (Mr. E was initially assessed as at medium risk of harm from Mr. Z and later in July 2012 assessed as high risk of harm. Notably the extent of discussion about support available to Mr. E was

limited to telephone discussions between a social worker and Mr. E; the author notes that there are no written records held by SS between 20th July and 15th August 2012.

Social services suggest that conversations between Mr. E and the social worker were conducted whilst he was under the influence of alcohol (It is noted that Mr. E did "sound as if he were under the influence of alcohol" during the telephone contact with adult social services)*; *it is highly likely that the perpetrator was present during these discussions and the door step visit was inadequate as the perpetrator was present, the cumulative impact of these factors leads one to believe that efforts would have had greater impact if a problem solving approach had been taken, rather than one of 'this situation does not fit our criteria for assistance'.

The nature of the relationship between Mr. Z and Mr. E was never clarified; there was never a discussion about domestic abuse within the household other than when referrals were made by the nurse at MIU. There appears to have been an acceptance that this alcohol and violence fuelled homelife was a lifestyle choice for Mr. E, rather than agencies seeing him as a person at risk of being a repeat victim of abuse from a violent offender. It is of concern that Mr. E himself was not explicit about his sexuality to any agency, but we should not assume that he was ever encouraged to divulge this, there is certainly no evidence of this. We can only surmise that had he disclosed he may have had access to appropriate support services.

35. The visiting professionals were assessing Mr. E's mental capacity, it is of concern that contact was not made with the GP as there was evidence on file to suggest memory problems.

***The concern is that Mr. E may not have been aware of the dangers he was facing, these issues were not made explicit to him whilst he was sober. The second concern here is that no contact was made with Mr. E's family, who were helping him manage his finances and who were often the third party calling for police assistance during a disturbance. Opportunities to engage with the wider family were not explored; this is a significant missed opportunity; though it is entirely possible that even if matters had been made explicit to Mr. E, he may not have agreed to agency support*.**

Adult social care suggest that their approach to Mr. E was "over and above" what could be expected in these circumstances as Mr. E did not have care and support needs as defined by the "No Secrets" guidance (NO Secrets Guidance 2.3) "The broad definition of a 'vulnerable adult' referred to in the 1997 Consultation Paper Who decides?,* issued by the Lord Chancellor's Department, is a person: who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation". And 2.4 "For the purposes of this guidance

'community care services' will be taken to include all care services provided in any setting or context."

Whilst Mr. E may not have been in need of community care as per the "No Secrets" guidance and therefore not deemed a 'vulnerable adult'; he was nonetheless an adult with vulnerabilities and at risk of being a repeat victim of assault and possibly being financially exploited, this is supported by information shared with the panel chair from both perpetrator and victim family members.

Adult social care may have taken an entirely appropriate view of the type of service they could offer Mr. E (which Mr. E would not fit in to as he did not have care needs as outlined in the guidance) but other agencies did not have the same boundaries to defining a vulnerable adult and would therefore not have had the same limitations on what services and support might reasonably be offered to Mr. E, a referral would have been the best course of action, or at the very least a professionals meeting...this did not happen.

The most effective mechanism for dealing with this case would have been to have a professionals meeting to consider what services or support might be offered by other partner agencies. It is the author's view that this is the most significant omission in dealing with this case.

At the time, the systems in place were not as effective at dealing with adults with vulnerabilities; the Vulnerable Persons Panel (VPP) was created in 2014 and this structure has led to better multi-agency problem solving.

2.105 Mr. Z missed both his community alcohol service and addiction services appointments around the 22nd August; a letter was sent from ADSIS to advise him to contact them within seven days. Community Alcohol service discharged Mr. Z as he failed to attend.

2.106 On 23rd August Mr. Z was seen by the probation service, he was heavily intoxicated and seen with a number of cuts and bruises to his face, his explanation was that he had fallen. He visited again a few days later on the 29th, this time sober and advised the PO that he had an appointment with the addiction services.

2.107 On 4th September Mr. Z was assessed for housing support at the probation service, where it was once again reiterated that the risk he posed to known adults was high. Note the serious risk of harm assessment was raised from medium to High on 20th July 2012 by probation.

36. As part of the assessment by Heantun Housing (HH), there is discussion between Mr. Z and the housing support worker regarding his self-assessment of risk, i.e. how much of a risk he was to others. It is worth noting that Mr. Z self identifies risk to Mr. E as medium, only when Mr. Z has been drinking; Mr. Z also discloses that he is drinking on most days and is at medium risk of reoffending (by way of assault on Mr. E) as a result of his alcohol consumption. HH accept the referral and believe that Mr. Z will engage in support services.

2.108 On 11th September, Mr. Z visited the probation service once again; he was under the influence of alcohol and had apparently been in a fight suffering broken ribs. The PO elicited that he did not attend either the alcohol or addiction services appointments, he had also failed to attend the OAAP session

37. It is of note that at this meeting with the PO, Mr. Z is reported to have stated that he just wanted to be sent to prison. His alcohol consumption was rising; he was failing to attend appointments and failed to attend the alcohol programme session. Clearly there are significant signs of non-engagement with services, perhaps even a level of frustration about his situation. This was potentially a cry for help.

2.109 Mid-September the ambulance service received a call from Mr. Z, stating that he was experiencing convulsions, the ambulance crew attended but Mr. Z refused to go hospital.

2.110 On 18th September, Mr. Z attended probation very late for his appointment and was sent home as he was intoxicated.

2.111 On 20th September Mr. Z attended an appointment with Heantun Housing but did not engage and there are no further records of his engagement with Heantun Housing.

2.112 On 26th September, at a meeting with the PO, breach action was confirmed for Mr. Z's non-attendance at the OAAP sessions, with a court date set for October 2012.

2.113 On 8th October 2012 Mr. E attended the hospital for an MRI scan, which identified significant brain atrophy, consistent with his heavy use of alcohol.

38. This information was shared with the GP but no further steps were initiated to assess capacity, conduct memory tests or to assess any deterioration. There was no reference to further action taken by the GP. The family perspective was that Mr. E had health problems and had brain damage, loss of hearing and loss of sight in one eye. His sister managed his financial affairs and did the shopping for him so that he had food to eat. In their view Mr. E needed help from agencies.

2.114 On 9th October Mr. E attended A & E as a result of a head injury, sustained in an assault on him by a person who he refers to as his house mate. Mr. E does not recall much and was unsteady on his feet with slurred speech. He was transferred to a ward and a CT scan carried out; he was discharged the following day.

2.115 Mr. Z did not attend his court hearing on 9th October and a warrant for his arrest was issued from Rugeley Central Unit.

2.116 On 11th October, Mr. Z attended the probation office. He was advised to go to court as there was a warrant for his arrest; the probation service contacted

ADSIS who explained that Mr. Z had been discharged as he failed to engage (he did not complete the self-assessment forms). Mr. Z had a black eye as a result of being beaten up. There is no further detail from any agency on this incident.

39. The author prompted further investigation into the matter of the warrant as there appeared to be some confusion as to why neither Staffordshire Police nor West Midlands Police had taken action to execute the warrant, it needed to be established whether this was a single procedure failure or a more systemic problem with the way warrants were executed at that time.

On further investigation by Staffordshire Police it emerged that in 2012, it was the responsibility of court enforcement officers to execute warrants, it remains unclear what action they specifically undertook as all their contact sheets were handwritten and only paper copies were maintained, the system appears to have had the potential to be ineffective and problematic.

However, currently the system has been modernised and automated, an electronic notification is sent to the relevant police force and can easily trace what activity took place to execute a warrant and thereby assess any delays or concerns about failure to execute warrants in a timely way.

2.117 Around the week of 20th October Mr. Z failed to attend several appointments: meetings at the probation office, the GP and a hospital appointment.

2.118 On 1st November Mr. E attended A & E stating that he had sustained another head injury whilst fighting with someone, after hospital investigations no acute injury was found, but there was bruising to the ear, head and arms and a minor head injury was diagnosed; he was discharged the same day. There is no reference to how this injury occurred nor who the perpetrator was.

2.119 On 1st November a referral was also made by the police for Mr. E to ARCH an agency that supports survivors of domestic abuse. Unfortunately, due to an office fire at the organisation the paper records were destroyed and there was no further information on this referral, nor do Staffordshire Police have a record of this referral. However, the agency report that it is likely that the male domestic abuse worker would have made contact in line with local practice and procedures, but there are no records of contact beyond this referral.

40. It is disappointing that there are no formal records of this referral; this could have been an ideal opportunity to commend the actions of an officer for making an appropriate referral in this case. It also raises the question about any potential disclosures Mr. E might have made about his sexuality, which may have led to this referral.
However, ultimately no records of service provision exist.

2.120 On 6th November an ambulance was called to the home address where Mr. Z had suffered alcohol induced seizures; he refused transport to hospital and was advised to see his GP.

2.121 On the evening of 9th November 2012 an ambulance attended to help a patient who had been assaulted in the street near to an alley way close to the victim's address. The victim was Mr. E; he had a serious head injury; he was unconscious with heavy bleeding to the head. Once transferred to the trauma unit of the hospital he was found to have multiple complex facial fractures, a collapsed lung, multiple rib fractures and an abdominal aneurism.

2.122 Mr. Z was arrested and charged with the assault. Mr. E was admitted to hospital and then into long term residential Care until his death in June 2015, whereupon Mr. Z was charged with Mr. E's murder; he pleaded guilty and was sentenced.

3 Analysis

3.1 In this section of the report the author examines and evaluates the involvement of the agencies that came into contact with Mr. E and Mr. Z, with regard to the terms of reference for this review. The agencies' own analysis contained within their reports is referred to and examined, as well as the discussion and comment from panel meetings. The views of Mr. E's family were sought as were the views of Mr. Z himself**.**

3.2 In analysing the information that emerges during a review such as this, the intention Is to avoid the 'wisdom of hindsight', and rather to look openly, critically and constructively at the decisions and judgements that were made at the time, in context of the time, with the information available at the time and with the emphasis on learning rather than on any sense of fault-finding or blame. The ultimate aim is to consider 'what might have made a difference' in this case, and what therefore is the learning from this review that might make a difference in future. Agencies were asked to consider where policies and practices were amended or updated since the time of the initial fatal incident.

Key Themes arising from the Review

The frequency of injury to Mr. E

3.3 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. It is important to acknowledge that there was an occasion when doctors (at A & E) had recognised that the injuries were not consistent with what Mr. E had said. The hospital exercised its professional judgement and commented in case notes; stating that injuries were not consistent with what was being said

or presented, but they did not take this information any further, nor is it clear that enough questions were asked of Mr. E. This demonstrates that there was sufficient professional inquisitiveness but a lack of referral or follow up action.

3.3.1 It is quite possible that agencies might have picked up a pattern of injuries if it was a female presenting with such injuries on account of improved staff awareness around domestic abuse. However, Mr. E's personal circumstances were not considered at times, and at others there were references to being friends and housemates with Mr. Z, consequently Mr. E's repeat injuries were not linked, reported or shared with any other agency. This is problematic from the perspective that equality of access to domestic abuse services was not afforded to Mr. E as a gay man. The continued lack of clarity about Mr. E being gay and the alleged violence from a lodger/friend/housemate/or partner simply compounded and confused any assessment of need by professionals.

3.3.2 It wasn't until July 2012 when, after coming into contact with Mr. E, two referrals were made within a week of each other by the hospital (MIU shared this information with the hospital) to the adult social care team for a contact assessment after Mr. E explained that he was being assaulted by Mr. Z. It was effective practice to follow this information up; this was a significant event in that it was an opportunity for a more cohesive and focussed level of support to be offered to Mr. E. The protocols were followed to enable contact to be made initially through Adult Social Care and then through Specialist Adult Protection Investigation Team. Records show information about the situation was shared with probation and police and a call was made to the GP (but there is no record on file from the GP of this contact.) It is recorded within the MASH information sharing document that Mr. E visited the MIU thirty-nine times in two years and that Mr. E has presented "possibly four times with head injuries". Whilst the information sharing was inclusive in its approach and the risk levels recorded as high rather than medium based on the information, the follow up actions were significantly deficient.

3.3.3 The GP was regularly sent notification of contact that Mr. E had with the hospital, including information about head injuries but there is no record of these matters being discussed with Mr. E or evidence that the GP recognised the issue of Mr. E having repeated head injuries, this too was a missed opportunity, showing a lack of professional curiosity and linking of incidents.

Mr. Z's significant history of violence

3.4 In May 2012 there were opportunities for agencies to effectively manage Mr. Z's violence proactively, reducing the chance of repeat victimisation of Mr. E. The SDR (Sentencing Delivery Report) written by the probation service to Courts had crucial information missing relating to Mr. Z's previous convictions and CPS notes, this led to an incomplete risk assessment and consequently there were no exclusion zones or conditions attached to the Suspended Sentence Order which might have better safeguarded Mr. E. Whilst this error was not considered to be systemic it led to insufficient risk assessment until July 2012, when MIU made a referral.

3.4.1 The nature of the relationship between Mr. E and Mr. Z appears not to have been explored in enough detail; protective measures were not put in place to safeguard against future victimisation; measures which might have otherwise been put in place had it been a female victim or if there had been clarity about the physical abuse/the nature of the two men's relationship and the number of repeat incidents. There were opportunities to clarify the situation in July 2012 as part of the Multi-agency Information sharing document.

3.4.2 There was significant information available to agencies regarding Mr. Z's previous violence on agency systems e.g. Staffordshire Police and West Midlands Police and there were opportunities (as identified in the previous paragraph) for agencies to contact one another to effectively manage Mr. Z within the community. A MAPPA (Multi Agency Public Protection Agency) referral was considered in July 2012 but Mr. Z was not eligible for referral as he was not subject to a custodial sentence.

3.4.3 On police responding to call outs during 2012 there was insufficient reference to Mr. Z's significant violent tendencies; this should have been taken into consideration irrespective of the nature of the relationship between the two men.

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

3.5 Mr. E had struggled with alcohol for many years; however, there might have been earlier intervention in supporting Mr. E with his drinking problems, through the primary care gateway. There is evidence on GP records that there was a deteriorating impact on Mr. E's health, affecting his diet, general health and alcohol related seizures. There is considerable information recorded on hospital, police and ambulance service records of him being regularly under the influence of alcohol at the point of service delivery and the frequency of assaults that he was subjected to, particularly in 2012 (as referenced in the MASH assessment).

As early as 2011 Mr. E's brother had recognised that he had physically deteriorated and that he was not looking after himself properly on account of his alcohol abuse. It was not until October 2012 that records show that Mr. E was finally offered referral to alcohol support services, which he declined. This is too little too late; opportunities to offer alcohol support to Mr. E were available but not pursued by agencies e.g. referral opportunities from the police, hospitals and GP services.

3.5.1 Mr. Z's records show that he came from a family of heavy drinkers and had been drinking alcohol from a very young age. 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 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, (in particular the new GP service that Mr. Z joined, this was not the same surgery as Mr. E) however his

chaotic lifestyle resulted in a cycle of dependency and failed attempts to stop drinking. Strikingly at the point of contact with the probation service he acknowledged that the only way he would stop drinking would be if he were in prison.

Capacity for decision making/ service refusal

3.6 The Mental Capacity Act 2005 is a legal framework which protects people who may lack capacity to make decisions for themselves. It also sets out how decisions should be made on their behalf. The act covers all sorts of decisions, from life-changing events to everyday matters. The act says that:

"a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or disturbance in the functioning of the mind or brain."

Adults are considered to be able to make informed choices about their safety and how they live their lives as well as the risks they want to take.

3.6.1 In August 2012 Mr. E was considered to have capacity under the terms of the Act, however the author is mindful that this assessment was carried out without reference to the GP, on the doorstep of the house and in the presence of the perpetrator and whilst both were under the influence of drink; these conditions are far from the ideal and in the authors view fall someway short of an effective assessment.

3.6.2 Agencies report that both Mr. Z and Mr. E had the capacity to make decisions, thereby making it difficult for agencies to insist on service provision. However, it is accepted that during the early part of 2012 Mr. E presented at his GP's surgery with memory problems, but no formal capacity test was carried out. There are records about brain atrophy, hearing and sight concerns for Mr. E; cumulatively this would have had an impact on his ability to manage himself, fully understand and be cognisant of the risks he was taking. He was also regularly under the influence of alcohol at the point of contact with almost all the agencies on more than one occasion, this also will have impeded his capacity to make coherent decisions and fully informed choices.

3.6.3 Given the views expressed by the family and Mr. E's general reluctance to share information in order to protect Mr. Z it is plausible that when the police or hospital were involved Mr. E may well have "played down" anything that had happened between himself and Mr. Z; this is supported by the views of Mr. E's brother who commented on the fact that Mr. E would protect Mr. Z when the family raised concerns about the violence in the relationship.

3.6.4 It is notable that at no point did agencies seek to refer, jointly visit or signpost Mr. E to alcohol support services.

3.6.5 It appears that officers from all agencies too readily chose to see Mr. E and Mr. Z as alcoholic co-dependents where violence was the norm', rather than consider their vulnerabilities in any detail. The reasons behind this are complex; it may have been seen as a lifestyle choice by agency personnel; Mr. E may have been perceived as a' time waster'; there may have been negative attitudes towards his alcoholism. In any event, agencies missed

opportunities to engage with each other to consider the extent of Mr. E's vulnerability and risk and this may have impacted on the level of support offered to him.

3.6.6 It is no stretch of the imagination to suggest that as a consequence Mr. E received a poor level of service, or at the very least, less of a service than may have been afforded to a female victim of domestic abuse as agency personnel may have felt more equipped to consider domestic abuse within a heterosexual context. It is however accepted that there are no official records of how Mr. E identified and there were mixed comments about whether he and Mr. Z had ever been in a relationship, this level of confusion made it difficult for the appropriate services to have been offered.

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.

The nature of the relationship between Mr. E and Mr. Z – power, vulnerability and exploitation

3.7 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, though there were several references to Mr. Z being Mr. E's partner, tenant, friend, drinking buddy. Beyond Mr. E's connection with Mr. Z the issue of his vulnerability was explored at times by agencies, but this was insufficient and information sharing at a much earlier stage would have been appropriate in order to assess risk and vulnerability. It is accepted by the family and Mr. Z that there was some benefit for both Mr. Z and Mr. E to maintain their friendship. For Mr. E, there were mutual interests and companionship and for Mr. Z he was able to live rent free with Mr. E, the family felt that Mr. E was being exploited by Mr. Z. The author believes this does suggest some kind of co-dependency between the two men.

3.7.1 Whilst patients/users have the right to keep personal information private there is little evidence of agencies proactively seeking to understand Mr. E's personal circumstances; this led to there being limited information on record with any of the agencies about the relationship or indeed the length of time the two men had lived together leaving the potential for insufficient support services.

3.7.2 Whilst there is inconclusive evidence that Mr. E and Mr. Z were in an intimate relationship during the years they were living together, they nonetheless had what appeared to be 'a co-dependent relationship', where Mr. E was desperate to maintain contact with Mr. Z.

3.7.3 Agencies acknowledged their relationship as friends, housemates or drinking buddies; agencies were not aware that Mr. E was gay and when calls for attendance were made from the home the police records note that the initial call type was sometimes recorded as a domestic but on arrival the two would be under the influence of alcohol and say they were friends or housemates.

There are records of third party reporting making reference to Mr. E and Mr. Z being partners; which on one occasion was corroborated by Mr. E himself on a call to Staffordshire Police, but each time a visit was made they reported as anything but being partners when asked by the police. We should also note that same sex relationships are not always easy to be open about complex issues of society, culture, faith and fear of reprisal may impact on disclosure; 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.

3.7.4 The author questions the extent, depth and detail of the information gathering of Police officers, information about Mr. Z and his violent tendencies are not identified as a risk factor nor the number of calls made to the address linked to each other and consequently vulnerability is not assessed effectively. The HMIC Peel Inspection for Staffordshire 2015 records "There are significant weaknesses in the force processes to identify repeat and vulnerable victims and there are unreliable and ineffective processes to assess the potential risks posed to victims with vulnerabilities. Some officers do not always recognise and respond appropriately to victims' vulnerability.

3.7.5 West Midlands Police record that "Mr. E's sexuality is not clear" however in 2002 officers had cause to visit Mr. E at his home and observed sexually explicit images of men on the wall. In April 2005 he was assaulted by a group of young men who shouted 'homophobic abuse' at him during the attack. This is corroborated by anecdotal information from the family who suggested that Mr. E was 'hounded out' of his previous home.

The family have also commented that "he left Wolverhampton because he had got in to trouble with people because he was gay". This commentary supports the viewpoint that 'coming out' as gay in some conservative communities is not an option.

3.7.6 This does then present a challenge around why agencies did not know very much about Mr. E's personal circumstances. It is plausible that agencies may have been reluctant to establish the exact nature of the relationship; this may be due to a lack of awareness around same sex relationships or 'blindness' towards acknowledging it. Indeed, Mr. E himself may have been reluctant to be open about his status for fear of poor treatment from agencies and so was not forthcoming.

3.7.7 Several agencies came in to contact with Mr. E and Mr. Z separately and together e.g. police calls for service, most of which were 999 calls Staffordshire Police (sixteen calls), West Midlands Ambulance Service (twelve), probation service, social workers, hospitals etc. However, agencies did not fully test assumptions around their relationship; nor did they robustly seek to consider Mr. E's vulnerabilities particularly around his re-victimisation, health and alcohol problems.

3.7.8 Staffordshire Police note that family members had commented that Mr. Z often turned up to see Mr. E around pay day; his sister is reported to have helped Mr. E manage his finances, so that bills and food were paid for and the rest of his benefit was spent on alcohol. During a meeting with the perpetrator, he suggested to the author that he and Mr. E enjoyed similar activities and that things tended to get out of hand when they were under the influence of alcohol, "Mr. E knew what buttons to press". Though Mr. Z expresses there was no coercion within the relationship, he acknowledges that he wanted to continue to live with Mr. E as he provided rent free accommodation. The family also reports that Mr. Z made no contribution to the rent or food. It appears that there is likely to be an element of exploitation within this relationship.

Lack of co-operation/ engagement with agencies

3.8 Both Mr. E and Mr. Z were engaged with agencies, sometimes cooperating and compliant and at other times aggressive and suspicious. Agencies identified Mr. E's vulnerability as a concern and some multi-agency discussions around risk took place. It is unclear whether Mr. E's lack of engagement was due to reliance on Mr. Z or the fact that Mr. E was in fear of him, either way this hindered agencies' ability to engage effectively.

3.8.1 Mr. E had two siblings living locally who were concerned for his welfare; there was a lack of agency engagement with the third party calls for assistance; this was a missed opportunity to explore the exact nature of the relationship or gather more information about the violence.

3.8.2 It is evident that there was considerable agency input in to working with both Mr. E and Mr. Z during the period in scope for this review. However it is also clear that there were opportunities missed to liaise with partner agencies when concerns might have been raised about the repeated violent nature of the assaults on Mr. E. Agencies did not take the time to meet with him separately whilst he was sober or elicit the support of family members to discuss his needs and identify what the issues were; this is a significant missed opportunity to offer appropriate support.

3.8.3 Mr. E was visited by two officers from the Adult Investigation Team, the visit was conducted on the doorstep as Mr. E would not allow them in, Mr. Z was also present. This is poor practice, Mr. E was not spoken to alone without the influence of Mr. Z; it is custom and practice for many agencies to operate separate dialogue with each party in circumstances like these; this did not happen in either of the opportunities where risk was assessed, i.e. the visit to Probation and the door step visit from social services.

It also demonstrates a limited amount of professional curiosity given that this was an adult protection issue and the perpetrator was present at the time of the discussion. There is limited evidence that discussion took place with Mr. E whilst he was sober about his vulnerability and what specific support might be offered.

3.8.4 It is acknowledged by the Social Services Information Sharing Document , that at the time of the referral probation services were the organisation who

had ongoing contact with Mr. E". However Mr. E was not a client of probation he was the victim and an opportunity to hold a 'professionals meeting' about any next steps would have been appropriate under these circumstances as the risk to Mr. E was still high; this did not happen, instead a letter was sent Mr. E outlining support he could get with alcohol addiction or to contact the police. In the author's view the outcome of this was wholly inadequate.

3.8.5 In July 2012 social services made attempts via the telephone to engage with Mr. E whilst he was under the influence of alcohol, each time he refused. Information sharing at an earlier stage (April/May 2012) between probation, police and the GP might have enabled a clearer understanding of the issues and risks and allowed agencies an opportunity to advise Mr. E at a time when he was sober.

3.8.6 Both Mr. Z and Mr. E did not engage well with agencies and this did make it difficult to develop ongoing contact; however, there were a number of opportunities missed to be better informed about the case which were not pursued by agencies.

3.8.7 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. It was effective practice for his new GP surgery to acknowledge his drinking problems and offer some support, although he was not able to formally take this up as his lifestyle continued to be chaotic and he struggled with abstaining from alcohol.

The probation service endeavoured to help Mr. Z manage his alcoholism through a drinking diary and following up on whether contact had been made with the relevant agencies, but this was not enforceable through any formal route.

Communication between agencies

3.9 There were some opportunities for agencies to share information, which were taken and used effectively, for example the safeguarding referral to adult social care resulted in a MASH information sharing opportunity between Probation, the police, hospitals and addiction services. However there were several opportunities for more information sharing at an earlier stage, for example 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. With the information available one would have expected that there would be some follow up between the police and probation service; this was a missed opportunity to respond appropriately.

3.9.1 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.

3.9.2 It is apparent that there were gaps in the information that agencies held, opportunities to seek further information were not taken up by practitioners, nor offered to Mr. E; this did not aid the situation. Notably the GP was not part of any of the communications but would have added value to the discussions.

Record keeping

3.10 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 20th July 2012 until 15th 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.

3.10.1 A significant factor which is relevant to this case refers to the lack of information around Mr. Z's previous convictions; this led to incomplete references within the SDR (Standard Delivery Report, an initial report which looks at the degree of culpability of the offender and the offence, attitude to the victim) which led to gaps in the pre-sentence report.
It is reported that at these key times not only did the probation officer not have access to relevant CPS records, but that the interview had to be carried out by video link and most importantly that no information regarding previous convictions was seen or referred to.
Mr. Z described his relationship with Mr. E in terms of "best friend." No attempt appears to have been made to check with the police directly as to other call outs etc to the home address. If the victim had been female, checks would have been made with the police as to background information regarding the relationship and much more attention would have been paid to the suitability of this post court address.

3.10.2 There is evidence that sometimes Staffordshire Police did not complete or finish STORM question sets, (the telephone risk assessment tool utilised by control room staff) which are required to be completed where there is a domestic incident initial call type. Given the previous history of contact, any reported incident involving them should then have resulted with consideration of a Domestic Abuse Incident – either Crime or Non Crime – and perhaps explicit instruction to attending police officers to explore the existence or otherwise of an intimate relationship between the two men.

3.10.3 The panel found that there was confusion around the court administrative process for arrest warrants in 2012; it seems on more detailed investigation the paper-based warrant system operational then was operating from a unit in Rugeley and run by court enforcement officers rather than police. The author's view is that this system was cumbersome and problematic. The new system is an electronic system and is more easily accessible for interrogation of data by relevant agencies.

3.10.4 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 Reflections from the Family

Family background

4.1 Mr. E was one of five siblings and was younger to his brother by one year. They lived nearby one another and saw each other regularly, almost on a daily basis. Mr. E was a keen pool and football player and was a member of a local team, much of this social activity stopped when he moved to Cannock and Mr. Z was his main contact, all his other friends were in Wolverhampton. Mr. E had lived in Wolverhampton for almost twenty years and moved back to the Cannock area when his mother's health deteriorated. Mr. E's brother felt that Mr. E had become increasingly isolated with limited contact with the family and contact with Mr. Z only.

Feelings of guilt and frustrations from the family

4.2 Mr. E's brother biggest regret was that he didn't do anything to sort Mr. Z out, he said: "I regret not dealing with Mr. Z myself, he was a nasty piece of work...maybe he (Mr. E) would be alive today".
Mr. E always called his brother straight away when there were problems.
"The whole thing is tragic and sad, two lives wasted".

Mr. E's health issues

4.3 Mr. E's brother stated he thought that Mr. E was not able to manage daily tasks himself, he and his sister often helped out with food, shopping, paying for electricity meter etc. Mr. E was said to be blind in one eye, had problems with mobility, was brain damaged and was deaf in one ear because of injuries sustained from Mr. Z.

Violence within the relationship and agency contact

4.4 Mr. E would always let him back in, try to cover up saying he didn't do it when he was hurt or saying he'd walked into the cupboard. If that was a woman the police would have maybe sorted it, but he was a man. Mr. E's brother stated he told Mr. E that "he will end up killing you" but he just ignored him, he would swear it wasn't him, or that he had just fallen over, anything to cover up. His injuries were always to the head with lots of trips to the hospital and I would get a call to pick him up, I've lost count of the number of injuries he had. He had called the police several times and they "just used to put the phone down on me, I wanted it recorded that he (Mr. Z) was assaulting my brother, to see if someone would do something about it". The police did not ever get back in touch with Mr. E's brother, even when he

had made calls to the police on behalf Mr. E. “No – one spoke to us, if it was a woman being battered it would be different”.
Mr. E’s brother stated that Mr. E would not have talked to social services; he would have been embarrassed and wanted to ‘keep it in the family’”.

The relationship between Mr. E and Mr. Z

4.5 Mr. E was “open at being gay”, they spent time together, it was companionship and not a “red hot love affair” and they were not intimate around Mr. E’s brother. They liked quizzes and drinking together. They spent a lot of time together Mr. E slept downstairs on the sofa and Mr. Z slept in a single bed in the front room.

4.6 Mr. E was in a relationship with a woman in the USA many years ago (about twenty years ago) the only other relationship was with Mr. Z. Mr. E’s brother stated that Mr. E “liked Mr. Z and feared being lonely more than anything. He always let him back. They were forced out of Wolverhampton due to him being gay”.

4.7 Mr. E’s brother believed that “Mr. Z was a ‘user’ and he would eat food and drink what was in the house, he didn’t pay anything, he might have not bothered if that stuff wasn’t available to him. Mr. E might have been alive today and if there was no money or food he (Mr. Z) would be mugging someone else off”.

When asked could anything have been done to help Mr. E?

4.8 Yes if he (Mr. Z) had been locked up. The police let him down and so did the courts. Mr. E might be alive now if he had been locked up for that assault in April. It was vicious and they had CCTV “Mr. Z should not have been allowed back into the house, there should have been some order on him or something to stop him going back to my brothers”.

Family visit after the conclusion of the Review

4.9 Following the conclusion of the review, the chair and author, Kam Sandhu, along with a representative from Staffordshire County Council, met with family members to outline the key themes identified within the review, to explain the process and to highlight the recommendations. The family welcomed the review and were accepting of the outcome. They recognised that it was too late to help Mr. E but it might help others in a similar situation. They commented that it was the volume and nature of the injuries sustained by Mr. E over several years which might have alerted agencies sooner; however, they accepted that he would not necessarily have been accepting of help from any of the agencies. The Overview Report and Executive Summary have been duly updated to record these comments.

5 Conclusions

5.1 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 who saw him on a regular basis.
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.

5.2 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 regularly be seen drinking with him in local pubs or at Mr. E's home.

5.3 The family considered Mr. Z to be 'using' Mr. E and taking advantage of his good nature. They were concerned about Mr. E's welfare and attempted to help Mr. E by calling the police when there had been an assault.

5.4 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.

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

5.6 The hospital made an appropriate referral to the emergency team for an assessment on 07.07.2012, this was dealt with rather superficially over the telephone; however 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 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.
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.

5.7 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.

5.8 Conversations about access to support services should not have taken place with the perpetrator present; **this is poor practice**.

5.9 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.

5.10 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 mechanism to force Mr. E to stop contact 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. Mr. E was not always willing to engage with agencies and this could have meant that any efforts made to intervene when opportunities presented themselves may not have been taken up. Nonetheless more robust attempts at ensuring Mr. E was coherent and sober enough to understand the risk he was in would have been better practice. 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.

5.11 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.

5.12 After the assault in April 2012, for which Mr. Z was convicted, there were errors in probation practice and procedural failures which resulted in incomplete information being used to risk assess the victim and perpetrator.

5.13 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.

5.14 Individual agency 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 Staffordshire 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 best effect.

5.15 Mr. E was an older gay man, with some physical health issues who was repeatedly assaulted by a known violent offender who had been living with him for several years and who was twenty-seven years younger; multiple agencies were regularly involved with both parties. In July and August 2012 there was some good practice in sharing information between agencies through a MASH referral, but this did not result in a definitive conclusion, a professionals meeting would have been the most appropriate course of action given the risks to Mr. E of being a repeat victim. Protocols were already in place for the option of a professionals meeting, these were not progressed and should have been, this was an untimely omission in the handling of this case. More robust efforts should also have been made to attempt to alert Mr. E to the risks he was facing and agencies might have considered engaging with the wider family to support him e.g. utilising the Think Family approach adopted by some local authorities, trusts and education departments.

5.16 The panel recognised that the likelihood of Mr. E accepting support or addressing the risks (by asking Mr. Z to leave) was unlikely given his previous reluctance to engage with some services. However, the key factor is that he was not afforded this opportunity, and agencies had opportunities to consider more robust options for engagement and assessment which were not progressed beyond the sign posting letter sent to Mr. E in August 2012.

5.17 Whilst it is highly unlikely that agencies could have prevented this death Staffordshire Police recognised “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”.

5.18 There is evidence to suggest that it was inevitable that there would be a repeat violent situation given the close proximity of Mr. Z to Mr. E, given that both were still heavy users of alcohol and that there was a co-dependency within the relationship it was highly unlikely that this cycle of behaviour was going to be broken. Agencies should however have tried to alert Mr. E to the seriousness of his situation and the likelihood of further violence.
One of the complexities of this case was that none of the agencies recognised Mr. E as a gay man and therefore did not make relevant referrals. This gap in their knowledge contributed to any interventions that could have been made. There were undoubtedly significant opportunities missed and professional errors made in assessing Mr. E’s vulnerability, which if managed more effectively could have had some impact on Mr. E. It is however highly unlikely that Mr. E would have taken steps to safeguard himself, his pattern of behaviour throughout the review period suggests that he was entwined in a toxic friendship which ultimately resulted in his death.

6. LESSONS LEARNT

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.

7. Recommendations

Individual Agency IMR Recommendations

WEST MIDLANDS AMBULANCE SERVICE (WMAS):

1. There are no specific recommendations for WMAS at this time, but the service will continue to provide training and raise awareness to ensure all WMAS staff have the confidence, opportunity, and resources to make timely referrals to the appropriate agencies.

SOUTH STAFFORDSHIRE AND SHROPSHIRE HEALTHCARE NHS FOUNDATION TRUST:

1. Ensure trust staff continue to provide expert support and advice relating to the Mental Health and Mental Capacity Act.

UNIVERSITY HOSPITAL NORTH MIDLANDS:

1. Liaise with voluntary groups to deliver domestic abuse training to staff:
2. ARCH - training session for ED staff (twelve members of staff) booked for the 1st December. Posters and helpline numbers are displayed in the waiting room and in-patient toilet areas. Women's Aid support the training on the County Site.
3. Keep an up to date assault data base to flag at risk patients.
4. All trained staff to prioritise attendance to Level one Safeguarding Adult training.
5. Trust working to improve psychiatric provision across both hospital sites to provide easier access for support as required.

SOUTH EAST STAFFS & SEISDON PENINSULA CLINICAL COMMISSIONING GROUP:

Practice A –

1. Discuss this case at a meeting of the clinical team, to ensure staff are aware of the importance of considering safeguarding referrals for a patient presenting with injuries on multiple occasions.
2. The practice team should review their existing safeguarding policies to ensure they meet current guideline.
3. To ensure all clinical staff have received training on domestic abuse, adult safeguarding.
4. To ensure the practice has a lead for adult safeguarding.
5. To audit current caseload of patients with recorded alcohol abuse to ensure appropriate referrals to addiction services have been offered or made.
6. To ensure all clinical staff have received training on the Mental Capacity Act.
    a. Mental Health Services.
7. To review referral pathway for addiction services due to non-attendance closing the referral; consideration should be built into the pathway for referral to other services e.g. social care.
8. Pathway should ensure GP is made aware of the lack of engagement due to potential capacity issues whilst under the influence of alcohol.

STAFFORDSHIRE POLICE:

1. Staffordshire Police to ensure that a corporate operating model exists across vulnerability hubs with specific regard to the identification and management of risk to vulnerable people – Independent of Domestic Abuse Force Procedures.
2. Staffordshire Police to deliver revised domestic abuse training package developed in partnership with the University of Gloucester to all Constable, Sergeant and Inspector Police Officers, Police Community Support Officers, and police staff.

STAFFORDSHIRE COUNTY COUNCIL:

1. Social care staff to make specific enquiry regarding MARAC in all cases involving domestic abuse and make referrals to MARAC when appropriate.

STAFFORDSHIRE & STOKE-ON-TRENT PARTNERSHIP NHS TRUST:

1. In order to ensure appropriate risk analysis, allocation of action and to ensure consideration of alternate agency support. A risk assessment process within a case conference or multi-agency setting MUST be carried out within ALL cases that demonstrate a high level of risk or 'refusal of intervention'.
2. Where agency risk assessment principles and policy guidance is not adhered to, due to lack of awareness – agencies to promote and redistribute appropriate training and policy guidance, an outcome being to improve risk assessment/risk management practice and potential risk management for the individual concerned.
3. A case co-ordinator to be identified within high-risk cases – To provide liaison to the individual, to coordinate and assure agency actions are carried out and to promote engagement, choice and control for the individual concerned.
4. Any agency intervention MUST be clearly documented in line with agency 'recording with Care' principles. The promotion and redistribution of appropriate training and policy guidance in order to achieve improved recording outcomes.
5. In order to achieve improved domestic violence awareness, guidance and information MUST be promoted within agency settings.
6. Where agency actions are not reflective of the Staffordshire and Stoke on Trent Safeguarding guidance, promotion, and training, where appropriate, MUST be undertaken in order to reduce actual or perceived risk to the individual.

NATIONAL PROBATION SERVICE:

1. Irrespective of the gender make up of victims and perpetrators active checks should be made with the police when writing reports for courts no matter what type of report or timescale. If the information cannot not be accessed in

the time frame allowed, an adjournment should be requested to avoid re victimisation.

2. The alcohol screening tool should be completed in all relevant cases at the report stage to ensure the correct targeting of provision takes place.
3. Report writers and court probation staff should give active consideration to continuing to protect the victim when there have been bail conditions to prevent contact between victim and perpetrator.
4. When probation officers are undertaking OASys assessments, where there is domestic abuse, regular contact with the police needs to be written into the risk management plan section and then regular checks undertaken.
5. When offenders attend the office with injuries, as well as active questioning in the interview, concerns should be triangulated with the police.
6. When cases are assessed as medium risk of harm and there are concerns as to the safety of ongoing living arrangements home visits should be undertaken.
7. When a case is escalated to high risk this should trigger a home visit automatically.
8. The IMR Author has discussed the need to call a professionals meeting with all probation staff interviewed in connection with this process and this is already embedded practice in the NPS. This report should be shared with the Head of Staffordshire-Stoke CRC.
9. When offenders state they are attending various provisions in the community this should always be triangulated.
10. NPS and police to discuss whether WWOB warrants can have a priority rating to ensure that those taken out on high risk of harm serious offenders are executed swiftly.

Requirements within a Serious Further Offence Report Action Plan

1. **All clusters to confirm they have systems in place to secure information e.g. CPS papers, pre cons, safeguarding, DV checks at the earliest opportunity from order/licence commencement.** *This has been completed by Staffordshire. Access to digital store now means this information does not need to be physically requested or transported.*

2. **Remind court staff and report writers and discuss in team meetings that where there have been bail conditions protecting a victim (including non-contact and exclusions) staff to proactively consider replicating these in their proposal through restraining order/exclusion requirements. This learning point to be shared with staff and included within serious further offence learning lessons bulletin.** *This was shared in team meetings across the LDU in February 2017.*

3. **Five cases of OM1 to be audited by SPO for evidence of <u>proactive multi agency communication</u>.** *This has been shared in teams meetings across the LDU in February and at the Divisional Heads Meeting in February 2017.*

4. **OM1 – Five cases to be audited to evidence <u>risk is being prioritised.</u>** *SPO liaised with OM1 and fed back to Head in May 2017 and Head met with OM1 in June 2017. OM1 is now a community rehabilitation company officer and has left the NPS*

5. **SFO learning lessons bulletin on Significant Events to be discussed with OM1 and staff in team meetings. Five cases of OM1 to be audited to evidence <u>comprehensive review</u>.** *The Lessons Learnt bulletin was shared at the LDU (manger's) meeting in September 2016 and also at team meetings in September/October 2016.*

Overview Report Recommendations

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

   Whilst there is now a process in place for adults with vulnerabilities to be supported through the CSP i.e. the vulnerable persons panel, information is not routinely shared between them and the MASH as effectively as it could be. This is particularly relevant where information is recorded on a single agency IT system and this is then not shared with the vulnerability hub, this is a gap in effective partnership communication.
   Action: For the CSP and MASH to develop a pro forma to refer/ share information with the vulnerability hub, this is especially pertinent where the MASH criteria are not met.

2. **To enhance the profile and understanding of the role and function of the CSH.**

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**

   Whilst MASH information sharing was acceptable in this case there should be an evidenced based record of a decision **NOT** to progress to a professionals meeting which sets out why it was not deemed necessary/appropriate and what alternative action will be taken, as required.

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.**

   Acute medical services recommend that "an up to date assault data base to flag at risk patients is maintained" (recommendation two UHNM) This 'frequent flyer' status should be shared with the vulnerability hub in order to better promote sharing of relevant information and demonstrate effective partnership working.

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.

Agencies do not routinely ask for all equality information consistently, in this case information about sexual orientation may have been pertinent in assisting agencies to better understand the vulnerabilities of the victim. Agencies should ask/record sexual orientation to identify if specific support services are relevant, promote inclusivity and develop good equality practice.

NHS doctors will be able to ask patients about their sexual orientation commencing 2019, under new health guidelines. The guidelines will advise medical professionals to keep a record of the patient's answer during face-to-face consultations – in an effort to ensure no patient is discriminated against.
e.g. LGBT networks note from BBC 15-10-2017 reported:

NHS England said lesbian, gay and bisexual (LGB) people were "disproportionately affected" by health inequalities such as poor mental health and a higher risk of self-harm and suicide.

It said public bodies had a legal obligation to pay regard to the needs of LGB people under the Equality Act 2010.

"Collecting and analysing data on sexual orientation allows public sector bodies to better understand, respond to and improve LGB patients' service access," the guidance states.

6. **To share the learning from this review within agencies and to disseminate it across the CSP to promote partnership working.**

It is recommended that this review be used as a 'learning tool' across the partnership agencies to expand and develop the knowledge and skills of staff working in similar situations in future. There should be evidence of the (anonymised) review being used in training and learning events with staff - both multi-agency and own-agency - to ensure that the lessons from it are embedded in future practice.

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.**

Through the partnership, agencies should take practical steps to raise awareness around male experiences of domestic abuse as victims, whether they are heterosexual or gay and the difficulties they may experience in raising their concerns with agencies of violence within the home.

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

   For all agencies to consider third party reports from family members should be recorded and where there are high levels of risk associated with repeat victimisation attempts should be made to engage with family networks that may be able to or already are offering support.

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.

Appendix 1 - GLOSSARY

ARCH: Third sector Domestic Abuse Service

CPS: Crown Prosecution Service

CSH: Community Safety Hub

DIAL: An internal police system – The DIAL is a Risk Assessment Form designed and used by Staffordshire Police to assess and mitigate the risk of harm to victims of domestic abuse.

MAPPA: Multi-Agency Public Protection Arrangements

MARAC: Multi-Agency Risk Assessment Conference relevant to high risk domestic abuse victims

MASH: Multi Agency Safeguarding Hub a central processing unit for safeguarding referrals

MISDD: MASH Information Sharing Discussion Document - a document used by a single agency to initiate information gathering when a referral is made to the MASH

MIU: Minor Injuries Unit: a walk-in hospital service (no longer in existence)

NPS: The National Probation Service

OAsys: An IT system of recording/assessing the risks associated with an offender

PNC: Police National Computer: a database detailing previous court disposal history and warning signals

PND: Police National Database: a search engine linked to other police systems in England and Wales

SDR: Service Delivery Report: a report compiled by the courts probation service to consider the offenders position in relation to the offence and previous convictions

SSO: Suspended Sentence Order

UHNM: University Hospitals of North Midlands NHS Trust

VPP: Vulnerable Persons Panel

Appendix 2

TERMS OF REFERENCE

DOMESTIC HOMICIDE REVIEW

CHASE COMMUNITY PARTNERSHIP

July 2015

Chair/ Author: Kam Sandhu

Date of Scoping Panel: **13th August 2015**

Date Last Amended: **7th September 2016**

CONFIDENTIAL

DOMESTIC HOMICIDE REVIEW TERMS OF REFERENCE

1 Introduction

1.1 The Terms of Reference for this Domestic Homicide Review (DHR) have been drafted in accordance with the statutory Guidance for the Conduct of Domestic Homicide Reviews, hereafter referred to as "the Guidance".

1.2 The relevant Community Safety Partnership (CSP) must always conduct a DHR when a death meets the following criterion under the Domestic Violence, Crime and Victims Act (2004) section 9, which states that a domestic homicide review is:

A review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse, or neglect by:

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

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

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

1.4 A member of the same household is defined in section 5(4) of the Domestic Violence, Crime and Victims Act [2004] as:

- a person is to be regarded as a "member" of a particular household, even if he does not live in that household, if he visits it so often and for such periods of time that it is reasonable to regard him as a member of it;
- where a victim (V) lived in different households at different times, "the same household as V" refers to the household in which V was living at the time of the act that caused V's death.

1.5 The purpose of undertaking a DHR is to:

- **Establish** what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
- **Identify** clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- **Apply** these lessons to service responses including changes to policies and procedures as appropriate; and
- **Prevent** domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

2 Background:

2.1 At approximately 2000 hours on the 9th of November 2012, neighbours heard noises in the street and found Mr. Z stamping on the head and body of Mr. E.

Mr. Z was subsequently arrested by Police and Mr. E was taken to hospital where it was found that he had sustained a severe head injury.

A Police investigation commenced, and Mr. Z was charged with an offence of Wounding with Intent – Contrary to Section 18 Offences Against the Persons Act 1861.

He was subsequently convicted and sentenced to an eleven-year five-month term of imprisonment.

Mr. E has remained in need of constant care and ultimately died on the 29th of June 2015 whilst at a Care Home.

He had been diagnosed with Bronchopneumonia.

On the 7th July 2015 a Home Office Post-mortem Examination was conducted, and the cause of death given provisionally as 1A pneumonia to the right lung caused by immobility. Further pathology work will now take place.

3 Grounds for Commissioning a DHR:

3.1 A DHR Scoping Panel met on 13/08/2015 to consider the circumstances. The Panel agreed that the following criteria for commissioning a Domestic Homicide Review had been met:

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

3.2 The recommendation to commission this Review was endorsed by the Chair of the Chase Community Partnership who was present at the Scoping Panel meeting on 13/08/2015 and the endorsement was minuted.

4 Scope of the DHR

4.1 Review will consider the period that commences from **1st AUGUST 2010** up to and including **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.

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

Name	**Mr. E**	**Mr. Z**
Relationship	Friend/ partner	Friend/partner
Age (June 2015)	62	34
Ethnicity	White British	White British
Sexuality	Homosexual	Heterosexual

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

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

5 Individual Management Reviews (IMR)

5.1 Key issues to be addressed within this Domestic Homicide Review are outlined below as agreed by the Scoping Meeting.

- 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 a vulnerable adult; and what subsequent steps were taken to manage this 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 addicted to alcohol, 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 is an element of coercion or control within the relationship

5.2 **Matters for the Review Panel (in addition to the above)**

- Identify from both the circumstances of this case, and the Domestic Homicide review processes adopted in relation to it, whether there is learning which should inform policies and procedures regionally or nationally.

- Consider aspects relating to the deceased and /or his friend/partner being vulnerable adults – a person "who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of himself or herself, or unable to protect him or herself against significant harm or exploitation'.

5.3 **Excluded matters**

- The Review will exclude consideration of how **Mr. E** died or who was culpable- that is a matter for the Coroner and Criminal Courts respectively to determine.

5.4 Individual Management Reviews are required from the following agencies:

- National Probation Service
- NHS England Midlands and East (North Midlands)
- South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group (SESSPCCG)
- Staffordshire and Stoke on Trent Partnership NHS Trust
- Staffordshire County Council Adult Protection
- Staffordshire Police
- University Hospitals of North Midlands NHS Trust (UHNM)
- West Midlands Police

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

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

5.7 In the event an agency identifies another organisation that had involvement with either the victim or perpetrator, during the scope of the Review; this should be notified immediately to Julie Long, Principal Community Safety Officer, Staffordshire County Council, to facilitate the prompt commissioning of an IMR.

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

5.9 Staff Interviews: All staff who have had direct involvement with the subjects within the scope of this Review, should be interviewed for the purposes of the DHR. Interviews should not take place until the agency Commissioning Manager has received written consent from the Police Senior Investigating Officer. This is to prevent compromise of evidence for any criminal proceedings. Participating agencies are asked to provide the names of staff who should be interviewed to Julie Long, Principal Community Safety Officer, Staffordshire County Council, who will facilitate this process. Interviews with staff should be conducted in accordance with the Guidance.

5.10 Where staff are the subject of other parallel investigations (Disciplinary, SUI, etc.) consideration should be given as to how interviews with staff should be managed. This will be agreed on a case by case basis with the Independent Review Panel Chair, supported by the Principal Community Safety Officer, Staffordshire County Council.

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

6 Summary Reports

6.1 Where an agency or independent professional has had no direct contact with the identified subjects within the period under review, but has had historic involvement with them, involvement with their extended family or is able to provide information regarding the provision of local services, a Summary Report should be prepared.

6.2 Summary Reports are required from the following agencies:

- ADSIS
- Arch North Staffs
- Cannock Chase Council
- Heantun Housing Association
- The Royal Wolverhampton Hospitals NHS Trust
- South Staffordshire & Shropshire Healthcare NHS Foundation Trust
- West Midlands Ambulance Service NHS Foundation Trust

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

6.4 The Summary Report should commence from the point at which the agency first became involved with the subjects until that involvement ceased. A chronology of **significant** events relating to family members should be attached to the report.

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

6.6 Summary Reports should be quality assured and authorised prior to submission.

6.7 In the event an agency identifies another organisation that had involvement with either the victim or perpetrator, during the scope of the Review; this should be notified immediately to Julie Long, Principal Community Safety Officer, Staffordshire County Council, to facilitate the prompt commissioning of an IMR.

7 Parallel Investigations:

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

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

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

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

8 Independent Chair and Overview Report Author

8.1 Ms Kam Sandhu is the Independent Chair and Author of this Domestic Homicide Review. Ms Sandhu has previously chaired a Domestic Homicide Review in Gedling, Nottinghamshire, a Domestic Abuse Scrutiny Committee for Nottinghamshire Police Authority, and a Multi-Agency Review in Staffordshire Moorlands. Ms Sandhu is independent of Chase Community Partnership and is not an employee of any of the agencies involved in the review.

9 Domestic Homicide Review Panel

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

- Arch (North Staffs) Ltd
- Cannock Chase Council; Chase Community Partnership – ASB
- National Probation Service
- NHS England; South Staffordshire Clinical Commissioning Group
- Staffordshire and Stoke on Trent Partnership NHS Trust
- Staffordshire County Council – Adult Protection
- Staffordshire County Council – Community Safety
- Staffordshire Police
- University Hospitals of North Midlands NHS Trust

10 Communication

10.1 All communication between meetings will be in confirmed in writing and copied to dhr.admin@staffordshire.gov.uk to maintain a clear audit trail and accuracy of information shared.

11 Legal and/or Expert Advice

11.1 The Principal Community Safety Officer, Staffordshire County Council, in consultation with the Independent Review Panel Chair, will identify suitable experts who would be able to assist the Panel in regard to any issues that may arise.

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

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

12 Family Engagement

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

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

13 Media Issues

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

14 Timescales

The review commenced with effect from the date of the decision of the Chair of the Community Safety Partnership, 13/08/2015 and should be completed and submitted to the Community Safety Partnership at the earliest time.