Domestic Homicide Review Overview Report:

EXECUTIVE SUMMARY

Adult A

Born: January 15, 1973

Died: June 5, 2014

Tony Blockley
Director: Johnston and Blockley Ltd

December 2015

Executive Summary

1. The review process

This executive summary outlines the process undertaken by The North Lincolnshire Safer Neighbourhoods Partnership domestic homicide review panel in reviewing the circumstances of the death of Adult A at the hands of his partner, Adult B. Criminal proceedings have been completed; Adult B has been convicted of murder and sentenced to life imprisonment. She must serve at least 14 years before she becomes eligible for parole.

The couple started a relationship in early 2013 although they had known each other prior to that date. They moved into a flat which had been rented by Adult B. On 5th June 2014, Adult A and Adult B had been drinking alcohol for most of the day. They argued and during the late afternoon/early evening, Adult B assaulted Adult A by punching him and scratching his face. The assault was not reported to the police. They continued drinking alcohol together and eventually they collected a Chinese takeaway meal and went back to the flat.

What happened next was witnessed by another couple who were in the flat with Adult A and Adult B. They said that Adult B 'flew' at Adult A and tried to put her hands around his throat. In the melee that followed, a knife block and knives were knocked off the kitchen worktop. Adult A fell to the floor and was sitting with his back to the units, legs outstretched, with Adult B kneeling in front of him. They said that Adult A did not defend himself or attack Adult B. One of the witnesses took two knives from Adult B, but she got a third one and stabbed Adult A once in his chest.

Adult A was taken to hospital but despite the best efforts of the medical staff, he died later that day.

On 24th June 2014, the North Lincolnshire Safer Neighbourhoods Partnership determined that the Adult A's death appeared to warrant the establishment of a domestic homicide review.

The following agencies were asked to provide chronological accounts of contact they had with Adult A, Adult B and anyone else they had been in relationships with during the 4½ years prior to Adult A's death:

- Humberside Police
- It's My Right Service
- Children's Services
- Northern Lincolnshire and Goole NHS Foundation Trust (NLaG)
- North Lincolnshire Clinical Commissioning Group - GP Services
- North Lincolnshire Children's Services
- East Midlands Ambulance Service
- North Lincolnshire Council Housing Advice Team Rotherham, Doncaster and South Humber NHS foundation Trust (RDaSH)
- Stonham/Homegroup
- National Probation Service (On behalf of the Humberside Probation Trust)

All of the agencies responded with the following having had some involvement with Adult A and/or Adult B:

- Humberside Police
- It's My Right Service
- Northern Lincolnshire and Goole NHS Foundation Trust (NLaG)
- North Lincolnshire Clinical Commissioning Group - GP Services
- North Lincolnshire Council Housing Advice Team Rotherham, Doncaster and South Humber NHS foundation Trust (RDaSH)
- National Probation Service (On behalf of the Humberside Probation Trust)

Those agencies produced reports covering the following:

- A chronology of interaction with Adult A and with Adult B
- What the interaction consisted of
- Whether internal procedures were followed
- Conclusions and recommendations from the agency's point of view.

<u>The police</u>

The police reported that by September 2010, Adult A had been in two relationships, both of which had involved domestic violence with him being the perpetrator. There were no more reported incidents until he met Adult B in 2013.

Adult B had several relationships dating back to 2001, all but one of which involved domestic violence with her being the victim. In July 2010, she was involved in an incident of domestic violence where she was identified as the perpetrator. There were no other recorded incidents of domestic violence until she met Adult B.

Between March 2013 and June 2014, there were five recorded incidents of domestic violence involving Adult A and Adult B. On all but one occasion, Adult B was the victim. The one incident where she was the perpetrator was when she smashed a bottle over Adult A's head causing a scalp wound. The police report stated that on every occasion, both had been drinking.

On one occasion during that period, Adult B was referred to MARAC. She did not engage with the process and her case was archived. This review has revealed that Adult B maintained her relationship with Adult A throughout the time the MARAC was ongoing.

<u>National Probation Service (reviewing the Humberside Probation Trust)</u>

The Humberside Probation Trust had limited involvement with both Adult A and Adult B. The Trust managed Adult B after her conviction for arson in 2010 and in March 2013, she was placed under supervision after she had been convicted of theft.

Rotherham, Doncaster and South Humber NHS foundation Trust (RDaSH)

Throughout the period of the review, Adult A attended the hospital on several occasions, presenting with alcohol dependency issues. On one occasion, domestic violence was discussed, but it was as a result of an incident, it was purely a discussion following his attendance for the alcohol related issues.

Adult B had limited involvement with the hospital in 2010 following an alleged drug overdose.

Northern Lincolnshire and Goole NHS Foundation Trust (NLaG)

Adult A presented on several occasions, generally in respect of alcohol related matters and there was a significant lack of engagement thereafter. He also visited the accident and emergency department frequently, where, against medical advice, he discharged himself before treatment could be given.

It's My Right Service

They were involved with Adult B during the MARAC process and they considered her to be a high-risk victim of domestic abuse. They had no contact with Adult A and had no reason to consider him to be at risk of harm from Adult B.

North Lincolnshire Council Housing Advice Team

They had limited involvement with Adult B in 2010/2011. Adult A initially asked for their help to secure accommodation but he managed to find somewhere himself.

North Lincolnshire Clinical Commissioning Group - GP Services

There was little information in the GP records; the following is an excerpt from the IMR:

'The GP records over the period of enquiry are generally sparse, and frequently illegible. There is little evidence of the patient being examined over a substantial period of time, and only the occasional blood test being arranged. There is no real evidence of any serious attempt to intervene in respect to the history of alcohol abuse until the diagnosis of chronic liver disease in May 2013. Overall, the evidence from the medical records alone suggests a very unsatisfactory level of medical care between 2010 and the time of [Adult A's] *death in 2014.'*

2. Key issues arising from the review

There were several incidents where risk assessments were not completed. Although there is no evidence that the lack of them contributed to the death of Adult A, it is important to recognise the need for full risk assessments to be completed in cases of domestic violence and abuse.

On one occasion in particular, Adult A was not immediately recognised as a victim and it appears that the information provided by Adult B was taken at face value.

North Lincolnshire Safer Neighbourhoods Partnership have now created a screening tool to help identify whether men are victims of domestic abuse. A recommendation is that the tool should be implemented across all agencies in North Lincolnshire.

Although Adult B was referred to MARAC, not all agencies were represented during the process. Full information sharing cannot take place in those circumstances and it is imperative that all agencies participate fully.

It is clear that both Adult A and Adult B used excessive amounts of alcohol which created difficulties managing their attendance and engagement with support agencies. It has been recognised that this is an on-going issue and one that is being addressed through additional training, awareness and information sharing protocols within all agencies.

3. Conclusion from the review

Adult A and Adult B were known to services although their engagement was inconsistent and challenging. They made the provision of support and assistance very difficult and the issues associated with it are being considered carefully by all agencies involved in the review and the North Lincolnshire Safer Neighbourhoods Partnership.

Nothing has come to light during the review that would suggest that Adult A's death could have been predicted or prevented.

4. Recommendations from the review

North Lincolnshire Safer Neighbourhoods

- Consideration for a single incorporated computer system to allow easy and ready access to information

- Ensure all agencies attend all MARAC meetings

Individual Agency

- All agencies should recognise the need to ensure risk assessments are used in all incidents of domestic violence and abuse and are to revisit training and awareness to reinforce this.

- All agencies should ensure their staff recognise that men can be victims of domestic violence and abuse.

- Humberside Police should review their risk-assessment process and provide further training and/or awareness for staff.

- National Probation Service should renew their guidance on the importance of risk assessments, home visits and consideration of wider safeguarding.

- The 'Freedom Programme' should be more flexible to ensure it can be

accessed by those that need it.

- Consideration should be given to the provision of perpetrator programmes to allow individuals to address their behaviour.