Stafford Borough Partnership

'Creating Competitive Advantage'

EXECUTIVE SUMMARY

DOMESTIC HOMICIDE REVIEW

in respect of

S

Female Born 1962

Report Author: Sue Lane

Accepted by
Stafford Borough Strategic Board
which incorporates Stafford Community Safety Partnership

1. Introduction

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

1.2 A duty on a relevant Community Safety Partnership to undertake Domestic Homicide Reviews, along with associated procedural requirements, was implemented by the *'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews'* in April 2011[1]. This defined a Domestic Homicide Review[2] (DHR) as:

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

1.3 The purpose of a DHR is to:

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

1.4 DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for Coroners and criminal courts. They are also not specifically part of any disciplinary enquiry or process; or part of the process for managing operational responses to the safeguarding or other needs of individuals. These are the responsibility of agencies working within existing policies and procedural frameworks.

1.5 The *'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews'* also provides for alternative review processes to be used in cases where the statutory criteria are not met but a Community Safety Partnership considers that a review would be beneficial.

1.6 This review was the first to be commissioned by Stafford Borough Council and within the wider area of Staffordshire County Council.

[1] www.homeoffice.gov.uk. This is reflected in the local guidance for agencies in Staffordshire: 'Staffordshire & Stoke-on-Trent Multi-agency Guidance for the Conduct of Domestic Homicide Reviews.'
[2] Domestic Violence, Crime and Victims Act (2004) section 9 (1).

2. Summary of circumstances leading to the Review

2.1 S was found dead at her home on a morning in October 2011 by her neighbour. She had been shot. The neighbour was alerted by parents of the children she cared for as a child minder who were unable to get a response when they brought their children for the day.

2.2 From an early stage the police identified her son J, aged 22, as the probable perpetrator. He has a criminal record in respect of drug offences and violent assaults which started while he was still of school age. He served a term of imprisonment during which he assaulted a member of staff. He was not subject to any formal supervision at the time of the death of S although he was subject to bail conditions.

2.3 Over the previous year J had received psychiatric treatment and had been detained in hospital on more than one occasion. Although he maintained a separate address, he was known to visit his mother's home on a daily basis and was closely supported by her.

2.4 Over the same period of time, J had been arrested on a number of occasions in respect of a range of offences. His mental health difficulties had resulted in delays in the legal processes and matters were not concluded at the time of his mother's death.

2.5 The death occurred during the half term holiday and S's daughter was staying at her father's home. However she normally lived with her mother and attended school locally.

3. Terms of Reference

3.1 The DHR considered the period that commenced from 01/01/2003 up to and including the events on the day that S died. The focus of the DHR was maintained on the following family Members:

Name	**S**	**J**	**R**
Relationship	Subject of DHR	Son	Daughter
Date of Birth	Aged 49	Aged 22	Aged 14
Ethnicity	White British	White British	White British
Address of Victim	Stafford, Staffordshire		

Key issues addressed within this Domestic Homicide Review as agreed by the Scoping Panel are outlined below for ease of reference.

These issues were considered in the context of the general areas for consideration as outlined by Staffordshire DHR procedures.

- Were risks posed by J to his mother, his sister, children minded by S, professionals and the community as a whole appropriately understood/shared/acted upon?

- Were S's concerns for her personal safety recognised, appropriately risk assessed and responded to?

- Should J have been identified as a Potentially Dangerous Person?

- Agencies' and professionals' understanding of the impact of child on parent violence and whether S was seen as a victim of domestic abuse

- The nature and effectiveness of agency involvement with childminding services provided by S and adherence to regulatory guidance by agencies

- Provision of mental health services to J,S and her daughter

- Referral to children's safeguarding services in respect of S's daughter

- Specific equality and diversity issues such as ethnicity, age, disability or vulnerability that require special consideration

- Was the homicide of S predictable and/or preventable?

4. Independent Chair and Report Author

4.1 The DHR Panel was chaired by Chris Few, an Independent Consultant and Chair of a Local Safeguarding Children Board. In Staffordshire Mr Few has chaired three other Domestic Homicide Review processes and two Serious Case Reviews. He has no other personal or professional connection with any agency in the County.

4.2 The Report Author, Susan Lane has undertaken similar enquiries and training commissions previously for safeguarding boards and is not employed by any of the agencies or associated bodies. She is an experienced and registered social worker and has previously held senior positions within children's social care and the Probation Service.

5. DHR Panel members

Head Of Policy And Improvement; Chair Of Community Safety Partnership; Policy, Improvement and Partnerships Manager	Stafford Borough Council
Chief Executive	Staffordshire Women's Aid
Co-ordinator	Domestic & Sexual Violence Local Development Project
Associate Clinical Director/Nurse Consultant, Mental Health Division - South Staffs	South Staffordshire and Shropshire Healthcare NHS Foundation Trust
County Commissioner for Safer Communities	Staffordshire County Council – Community Safety
Specialist Safeguarding Development Manager;	Staffordshire County Council – Strategic Safeguarding
Strategic Lead, Specialist Safeguarding Delivery	Staffordshire County Council – Families First Safeguarding
Lead Nurse Safeguarding Adults (South); Designated Nurse	Staffordshire NHS Trust Cluster of Primary Care Trusts
County Manager; Area Youth Offending Team Manager	Staffordshire Youth Offending Service
Head Of Stoke Probation and Snr. Manager for Staffordshire Courts	Staffordshire and West Midlands Probation Trust
Education Inclusion Partnerships Manager	Staffordshire County Council – Education Inclusion Partnerships
Early years Services Consultant; County Improvement Manager;	Staffordshire County Council – Education Transformation
National Advisor, Early Years Foundation Stage	Ofsted
Detective Chief Inspector; Family Liaison Officer; Detective Constable ; Crime and Policy Review Manager	Staffordshire Police Major Investigations Department (MID)

6. Review Process

6.1 The Panel met on 5 occasions and had the full support of the borough council as lead agency for the Community Safety Partnership.

6.2 Agencies submitted Individual Management Reviews (IMRs) and reports as requested in the terms of reference with the exception of the South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSSHFT). SSSHFT only

submitted an IMR in late September 2012 and this IMR did not provide as full an analysis of the issues as expected. Discussion of the issues in a subsequent meeting and discussion with the IMR author clarified most relevant issues. The delay in receiving this IMR significantly delayed the review which might otherwise have been completed immediately after the trial of J.

7. Contributors

7.1 Individual Management Reviews were required from the following agencies:

- South Staffordshire and Shropshire Healthcare NHS Foundation Trust
- Staffordshire County Council: Education Inclusion
- Staffordshire County Council: Child-minding Support Services
- Staffordshire County Council: Families First Safeguarding
- Staffordshire Police
- Staffordshire Youth Offending Service
- Staffordshire Probation Trust
- Stafford Borough Council
- Staffordshire NHS Cluster of Primary Care Trusts
- Ofsted

8. Parallel Processes

8.1 J was charged with murder and was remanded to the regional forensic unit. He was found unfit to stand trial. Stafford Crown Court found that he had committed the killing and he was ordered to be detained indefinitely in August 2012.

8.2 At each meeting the Panel sought and received assurance that S's 14 year old daughter was safeguarded and supported appropriately.

9. Family Involvement

9.1 S's daughter is living with her father. He was contacted by the Police family liaison officer and offered the opportunity for both of them to meet with the report author to provide the family's perspective on the events. This meeting did not take place at her father's request. Following revision of the report in 2014, R and her father were again contacted and both subsequently met with the Panel Chair and had opportunity to read the report. R explained that she considered her brother should have been detained in hospital longer and that the impact of his behaviour on her was never discussed with her.

9.2. A friend of S has met with the Panel Chair and has provided additional insight into the relationship between the victim and the perpetrator. S was loyal to her son, believing the best of him, and struggled to recognise his criminal activities although this was evident to her friend from his lifestyle. This information and source is referred to in the text where relevant. S's friend was also given an opportunity to read this report prior to submission to the Home Office.

10. Summary of Facts and Events

10.1 Agencies provided detailed chronological information about contacts with the victim S and J the perpetrator. This summary is drawn from that information.

10.2 The victim was known to her GP practice but otherwise had few contacts with formal agencies except in respect of matters relating to her children. No agency had any information to indicate that she was at risk of homicide or assault.

10.3 Throughout the period of the review S was a registered child minder, maintaining an active business to support her family. As a result she had regular contacts with Ofsted which holds the inspection and regulatory functions for this activity. She also had contacts with local early years training and support services.

10.4 The perpetrator J was known to the police and to mental health services. He was identified using illegal substances in the autumn term of 2003, aged 14 while he was a year 10 pupil. This resulted in his permanent exclusion from school. He continued to be involved in criminal activities throughout the period of the review although there appear to be times when this was less frequent and less serious. He was first convicted of offences in 2005, completed his last sentence in 2009 and was not subject to any sentence at the time of S's death. From the time of his first offence J lived for various periods first with other family members and more recently at independent addresses. He used his mother's address for correspondence and there were substantial periods when he was living there. When not officially living there, he was always a daily visitor.

10.5 J was arrested in early 2011 and this arrest and subsequent court appearances led to his detention under Section 2 of the Mental Health Act 1983 on three separate occasions from January to April 2011. The criminal proceedings were delayed by the concerns for his mental health and had not been concluded when S died. He was subsequently arrested in respect of her homicide and was ordered to be detained indefinitely following a finding of fact by Stafford Crown Court.

10.6 For much of 2011, when not detained in hospital, J was supported in the community by mental health services. His support was heavily dependent on his mother and he visited her home on a daily basis for meals and other practical help while maintaining an independent address. Both police and mental health services were aware that he routinely carried bladed weapons and he was found in possession on several occasions. His mother reported a fascination with knives to mental health services. There were contacts between the services but these contacts did not result in a thorough risk assessment or effective action based on all the information available to both agencies.

10.7 There were child protection referrals in 2011 relating both to the risk to minded children and to S's daughter. J's criminal activities and mental health problems should have led to some consideration of the risks in relation to both but neither children's social care nor Ofsted conducted sufficiently comprehensive enquiries to identify the risks. Neither service was aware of the full extent of J's offending, nor of his mental health and behavioural problems.

11. Key Findings

11.1 The Panel in reviewing the events, agency information and analysis focussed on the following key issues that emerged in Panel discussions.

a) Domestic violence where the victim is the mother of the perpetrator;

b) Risks presented by J through offending behaviour and mental health concerns.

c) Community Safety Strategies in respect of illegal substances and weapons.

d) Child protection matters in respect of S's daughter and in respect of child-minding registration.

11.2 **Domestic violence where the victim is the mother of the perpetrator.**

These events indicate that it is not only partners who may be at risk of violence within their own home. The Panel consider that there is a need to raise awareness of the risks to parents. Where adult children are known to be engaged in violence outside the domestic arena, there is an opportunity to make enquiries about any unreported domestic incidents, threats or bullying. A wider strategy is needed to raise awareness amongst parents of the risks to themselves from their children and amongst professionals to treat them with the same consideration as partners.

11.3 **Risks presented by J through offending behaviour and mental health concerns**.

There was a pattern of increasing complexity and seriousness in J's criminal involvements over a significant period of time from his early offending in 2003 to 2010/11. When his behaviour changed in late 2010, his mother was diligent in persuading him to seek treatment. She worked with the mental health services during 2011 to support him. There was insufficient information-sharing between police and mental health services and risk assessments were incomplete as a result. While there were no indicators for considering J within procedures for domestic violence or dangerous offenders, there was sufficient concern to warrant a more robust approach by both agencies. No carers assessment was completed in respect of S or her daughter.

11.4 **Community Safety Strategies**

While there may have been no specific indication to suggest that S was at risk of homicide, there was sufficient known about J's activities and those of his associates to suggest substantial general risks to the public from a wide range of criminal activities associated with illegal substances. Better focussed multi-agency information sharing and joint actions with a view to preventing crime in general may have reduced the opportunity for J to obtain and use an illegal firearm.

11.5 **Child protection matters and child-minding registration**

There were 2 different aspects to the child protection issues

a) The safety of S's 14year old daughter;

b) The safety of children receiving a child-minding service:

The risks were different for each, the remedies available were different, and each needed to be considered carefully and reviewed regularly. Opportunities to take protective action in respect of both were missed and action in one area did not routinely result in a review of the other. There were failures of communication as well as failures when facts were shared to recognise the seriousness of the risks by most agencies. S's daughter was never given an opportunity to explain how she felt about her brother's presence in the household.

12 Lessons to be Learned and Recommendations

12.1 Each agency has made recommendations to improve practice which are supported by the Panel. The recommendations and detailed actions are set out in the action plan. In addition the Panel considered whether there were matters that required further action.

12.2 The Panel have concluded that more robust decision-making by all agencies to contain and disrupt the high risk behaviour might have reduced the risk of this death but it is not likely it could have been prevented on the information available. There was little information either that could have led any professional to predict such an event.

12.3 There was a significant failure to evaluate jointly criminal and mental health concerns about J in March 2011 by police and mental health services. This failure might have been ameliorated in August 2011 but again the opportunity was not taken.

Recommendation 1

The Panel recommend that arrangements for routine information sharing between the police and NHS agencies are reviewed to ensure that they are robust and comprehensive to support effective and timely decisions by professionals to reduce risks to families, friends and the wider public from the consequences of criminal activity when exacerbated by mental health concerns.

Recommendation 2

The Panel recommend that whenever criminal activity is present and persistent in parallel with mental ill health, there should be regular forensic mental health led review to ensure that public protection is sufficiently considered.

12.4 The Panel are also concerned about the responses to child protection concerns in March 2011 and subsequently. These events do not meet the criteria for a serious case review however there are matters that require review by those responsible for child protection services that will not be fully addressed by the individual agency recommendations.

Recommendation 3

The Panel recommend that the Staffordshire Safeguarding Children Board should review this report and have access to any background details to assist them to consider the implications for the operations of child protection procedures and in particular Local Authority Designated Officers and the support that community safety arrangements may provide to those responsibilities.

12.5 In additional to responding to these concerns the Panel wish to draw attention of CSP agencies to the wider issue of parents abused or threatened by their adolescent or adult children. None of the agencies had any specific services or strategies to address this concern but discussions in Panel suggest that there may be less serious incidents and scope to prevent them. The Panel are particularly pleased that some agencies responded very promptly to this issue and have already taken steps that will contribute to realisation of the following recommendation.

Recommendation 4

The Panel recommend that the CSP consult with all agencies and consider how the matter of violence and abuse of parents by their teenage and adult children can be identified and prevented.

12.6. In addition to the above considerations, the Panel are concerned that there have been substantial delays and omissions as a result of the minimal cooperation with these procedures by SSSHFT and a lack of clarity about what other processes may also be required.

Recommendation 5

The Panel recommend that the Chief Executive of the South Staffordshire and Shropshire Healthcare NHS Foundation Trust review these processes and provides a report to the CSP and Trust Board within 3 months on the arrangements in place to achieve compliance with DHR procedures in the future.

12.8 The Panel are pleased that the Trust has recognised in its recommendations the need to robustly implement Care Programme Approach disciplines. The Trust recommendations do not however remedy the absence of a carer's assessment or support plan.

Recommendation 6

The Panel recommend that the South Staffordshire and Shropshire Healthcare NHS Foundation Trust ensure that legal obligations to relatives and friends of patients acting as carers are routinely met and robustly monitored.

12.9 The Panel remain concerned about the commissioning accountability for services provided by SSSHFT particularly in the light of NHS organisational change and therefore:-

Recommendation 7

The Panel recommend that the NHS commissioning body for the area consider what changes may be required to support effective accountability for managing risks presented by patients and ensure that these arrangements are subject to regular review.