Executive Summary

Domestic Homicide Review

Case of Sarah

South Lakeland Community Safety Partnership

Mark Yexley – April 2014

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STANDING together against domestic violence

SOUTH LAKELAND DISTRICT COUNCIL

Contents

Executive Summary

1. This summary outlines the process and findings of a review into the homicide of Sarah. The identity of those involved has been anonymised for the purposes of confidentiality.

2. On 21 August 2012 a domestic homicide took place in the South Lakeland district of Cumbria. The victim Sarah was killed by her son John. He has been found guilty of manslaughter and has been sentenced to 13 years imprisonment.

3. These events led to the commencement of this Domestic Homicide Review (DHR) at the instigation of the South Lakeland Community Safety Partnership (CSP). The initial meeting was held on 29 January 2013 and there have been three subsequent meetings of the DHR panel to consider the circumstances of this death.

4. The DHR was established under Section 9(3), Domestic Violence, Crime and Victims Act 2004.

5. The purpose of the review 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 those lessons to service responses including changes to policies and procedures as appropriate
- Prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

6. This review process does not take the place of the criminal or coroners courts proceedings nor does it take the form of any disciplinary process.

7. Terms of Reference

8. The full terms of reference are included in Appendix 1. The essence of this review is to establish how well the agencies worked both independently and together and to examine what lessons can be learnt for the future.

9. Methodology

10. The approach adopted was to seek Individual Management Reviews (IMRs) from all organisations and agencies that had contact with Sarah or John. It was also considered useful to involve those agencies that could have had a bearing on the circumstances of this case, even if they had not been previously aware of the individuals involved. Details of

those agencies providing IMRs or summaries of information held are outlined in the terms of reference.

11. Once the IMRs had been provided panel members were invited to review them all individually and debate the contents at subsequent panel meetings. This became an iterative process where further questions and issues were then explored. This report is the product of that process.

12. Composition of the DHR panel

- Crown Prosecution Service
- Cumbria Alcohol and Drugs Advisory Service (CADAS)
- Cumbria Constabulary
- Cumbria County Council Adult Social Care
- Cumbria County Council Children's Services
- Cumbria County Council Community Safety
- Cumbria Partnership NHS Foundation Trust (CPFT) – Mental Health Services
- Impact Housing and Let Go Domestic Violence Project
- NHS Cumbria Clinical Commissioning Group Primary Care
- South Lakeland Community Safety Partnership (minutes and administration)
- South Lakeland District Council
- Standing Together (Independent Chair)
- Unity Greater Manchester West Mental Health Trust
- University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT)

13. A full list of panel members is contained in Appendix 2.

14. Contact has been made with the daughter of the victim and she has been spoken to by the chair. She provided a valuable insight into the dynamics of the family and interaction with the community and statutory services.

15. The independent chair of the DHR is Mark Yexley, an ex-Detective Chief Inspector in the Metropolitan Police Service and a lay chair for NHS Services in London, Kent, Surrey and Sussex. Mark represents Standing Together Against Domestic Violence, an organisation dedicated to developing and delivering a coordinated response to domestic violence through multi-agency partnerships.

16. There have been no parallel or similar reviews conducted into this case.

The Facts

17. The death of Sarah

18. The victim, Sarah, was killed by asphyxiation on 21 August 2012 in her family farmhouse. She was 77 years old.

19. Sarah was a retired vet residing in a farmhouse in a remote rural community. Also living on the farm complex, were Sarah's two children. Her daughter Claire and her family lived in a self contained converted barn. Sarah's son John, the perpetrator, lived with his partner Debbie in a caravan sharing Sarah's cooking and bathroom facilities.

20. Sarah had not reported any concerns to agencies about her son before her death. Debbie had recently sought help for problems with alcohol misuse by John from Cumbria Alcohol and Drugs Advisory Service (CADAS). There were no concerns of domestic abuse raised.

21. Debbie later told police that about six weeks before the death of Sarah, she was woken in the middle of the night by John standing over her with a knife.

22. On the evening of 21 August 2012, whilst in an alcoholic rage, John killed his mother by asphyxiation in her home. John had told Debbie that he killed his mother and Debbie found her body in her bed.

23. John was arrested nearby and charged with the murder of his mother. He later pleaded not guilty to murder and was found not guilty. John pleaded guilty to a count of manslaughter and was sentenced to 13 years imprisonment.

24. Sarah - contact with statutory sector

25. Sarah and her family lived in a remote area. They were rarely visited at home by any services and would travel to local appointments when required.

26. The only contact for Sarah with any statutory bodies comes from her time as a patient with her NHS General Practice. She had been seen by her General Practitioner (GP), with minor self-limiting conditions. Sarah attended all appointments for routine vaccinations and screening. Three days before her death, Sarah attended her GP where she was treated for a medical condition. She raised no other concerns with her GP and she was not seen to have any injuries.

27. The perpetrator - John

28. The main areas of contact between local services and John came through incidents reported to the police and visits to the local GP practice, where Sarah was also a patient.

29. John was known to be living at his mother's farm in 2005. Police were called to the farm over an allegation that he had assaulted his niece. Police investigated

the incident and there was not found to be any evidence of assault. During the investigation John was found to be cultivating cannabis. He was cautioned for this and offered self-referral to drug and alcohol abuse scheme.

30. During 2005 there was also a breakdown in the relationship of John and his partner of that time. There was no reported domestic abuse.

31. In 2007 John commenced a relationship with Debbie. She resided in central England and they travelled to see each other.

32. In 2009 Claire called police to her home reporting that John was drunk and had tried to get hold of her, she expressed concerns about his escalating strange behaviour. The incident was recorded by police as a verbal argument. The incident was recorded by police. They followed appropriate policy and provided advice to Claire.

33. In 2010 John disclosed to his GP that he was drinking heavily and his mother had encouraged him to see the doctor. John was assessed as being alcohol dependant. His GP talked through strategies to reduce alcohol intake and provided John with details of Alcoholics Anonymous (AA) and CADAS. John did not make any contact with CADAS. John visited his GP a year later, but there was no mention made of alcohol dependency.

34. In March 2012 Debbie commenced living with John in the caravan. In July 2012, Debbie was asleep when she was woken in the middle of the night by John holding a knife; he told her that he did not kill her as a sign of his love for her. This incident was not reported to any agency. Debbie later informed police that she had a sometime violent relationship with John and they assaulted each other.

35. Later in July 2012 Debbie contacted CADAS, as she had concerns about John's alcohol consumption and the effect on their relationship. When Debbie attended her appointment she presented with her partner. During the interview high levels of alcohol consumption were disclosed by both parties. They were advised that they could self-refer to a one-to-one psychosocial support intervention service at that time or later. They did not take up the offer.

36. John was also recommended to see his GP to advise on safe reduction of alcohol consumption. It later transpired that on 20 August 2012, Sarah booked an appointment for John to enter a private rehab clinic on 22 August 2012.

37. On 21 August 2012 John killed his mother Sarah. He was arrested shortly after and found to be intoxicated.

38. Whilst in police detention John was referred to the Crisis Intervention Assessment Team (CIAT) for mental health assessment. John stated that he had been drinking heavily for 20 years. He said that on the day of the incident he said that his mother was nagging him and he 'lost it' and killed her. He was assessed be alcohol dependent and not mentally ill.

39. As the final element in the DHR process the perpetrator was interviewed. John stated that he had lived with his mother for 20 years and there was no history of violence between them. There was some hostility between him and his sister. In

considering his substance abuse he has not initiated any contact with support agencies. He said that the incident that sparked his mother's death was her action in booking him into a private rehab centre. He had argued over this and had been drinking heavily. His only comment on agency contact was that he felt they should be proactive in following up cases where substance misuse is disclosed.

Analysis

40. The following analysis examines the lives of the victim of this homicide and the perpetrator but nothing should detract from the fact that John took the life of his mother and he has been found responsible for that act. Nothing in the life of Sarah could ever possibly justify her death. It is considered that if the behaviour demonstrated by John with his partner in the months before the homicide had been communicated to responsible agencies, then steps would have been taken to assess the risk he presented to his family.

41. Sarah was a retired professional woman living in a farmhouse in a remote community. She accessed GP services when appropriate. She visited her GP three days before her death and was examined; there was no suggestion of concern over DV raised by Sarah. It is known that she had reported family stresses in the past to her GP, but there is no evidence to suggest that she would have been aware of the threat presented by John to his partner a few weeks before.

42. There are a number of recorded incidents in relation to alcohol misuse by John. He has stated that he has been drinking for twenty years.

43. When John's sister reported a domestic incident where she was concerned about his 'escalating strange behaviour' further steps could have been taken. This could have led to further investigation on the nature of his behaviour, raising John's status to that of a vulnerable person highlighting risks. Consideration should have been given to referring John to non-police agencies with a written notification being provided to him. Written information was provided to Claire. There was however no further contact between the family and the police.

44. In January 2010 Sarah was worried about the level of her son's alcohol consumption, but she had encouraged him to see to his GP rather than raise concerns. Between this time and her death Sarah had visited her GP on sixteen occasions and had not expressed any further concerns. There was no evidence to statutory or third sector agencies that John was in an abusive relationship with his mother or presented a risk to her.

45. When dealing with the concerns of alcohol consumption, the GP made a comprehensive medical assessment. However, GP relied on John self-referring to third sector agencies. There were no established lines of communication with these agencies to support the patient

in attending appointments and feeding back to GP services. There was no referral to default NHS statutory healthcare providers. A formal referral to an NHS provider could have compelled John to attend appointments and would have resulted in non-attendance being reported to the GP.

46. There was a further missed opportunity to check up on John's alcohol dependency. In January 2011 John attended his GP where he was examined for a medical complaint. There was no record of any discussion of the long-standing alcohol problems reported to the GP the year before and no check on whether he had taken up the previous advice.

47. John came to the attention of CADAS one month before he killed his mother. Although the initial contact came from his partner to discuss relationship problems, John accompanied her. Consideration was given to whether a meeting with both parties present was appropriate. However, given that the initial call to CADAS was to discuss relationship problems, this can be seen as a missed opportunity for either party to discuss DV.

48. The meeting with CADAS was also a missed opportunity to refer John to default NHS services for substance misuse.

49. The IMR process revealed Debbie had been woken in the night by John holding a knife. This incident may well have prompted Debbie's call to CADAS, but DV was never disclosed. She did not disclose this incident to any statutory or third-sector agency and she only told a friend. Consideration needs to be given to how public awareness of DV and third party reporting is promoted. Agency awareness of the incident would have resulted in immediate steps to assess the risks presented by John.

50. Before the death of Sarah there was no evidence within statutory agencies that she was at risk of abuse from her son. In this case neither Sarah nor Debbie had reported any threat or violence from John to agencies that may have provided help. The panel did not feel that the risk to Sarah from her son could have been predicted, based on the information available at the time.

51. With all the foregoing in mind the issues raised within the panel meetings and which should lead to further consideration for the future are as follows.

52. Information sharing

53. Information sharing is an essential element in the prevention and management of DV. There was a lack of inter-agency information sharing.

54. Within the police service there was information held on concerns held by John's sister about his strange behaviour in 2009. The panel considered that this information could have been developed by the police at the time to consider a community-based response.

55. When John was seen by CADAS July 2012 he was advised to see his GP concerning alcohol dependency. There was no process in place to formally follow this advice up.

56. There appears to be a lack of information sharing in place between CADAS and GP Primary care, however consideration needs to be given to confidentiality of clients visiting the CADAS service.

57. Risk Assessment

58. When John came to police attention an appropriate risk assessment was under taken in line with current policy. However risk assessment should be considered as an on-going and dynamic process that can develop and gather further information essential for identifying and managing risk. In making the risk assessment statements of escalating behaviour need to be explored.

59. When John reported level of alcohol consumption to his GP he was clinically assessed. This assessment should then have been developed to consider the risk presented by John to his family and community.

60. Understanding of the existence of DV

61. No agency involved in this DHR process was aware of any DV being present between Sarah or Debbie and John before the homicide.

62. John's partner had expressed concerns over the effect of his drinking on his relationship with her in a telephone conversation with CADAS, but she did not disclose that there was DV. DV and associated risks should always be a consideration when clients wish to discuss relationships. There should be processes enabling intimate partners to speak in private.

63. Police action

64. There are no concerns over the initial response to the death of Sarah. Cumbria Constabulary staff were provided with clear evidence and adopted appropriate investigation procedures taking immediate steps locate and arrest John, reducing the risk to the public.

65. Mental Health

66. There were no recorded concerns on the mental health of either party before the homicide.

67. Whilst in police detention for his mother's murder John was referred to the Crisis Intervention Assessment Team (CIAT) for a mental health assessment. The CIAT is a service provided by Cumbria Partnership Foundation Trust. At the start of the DHR process were no formal protocols between the trust and police for mental health assessments. This referral process could fall outside a DHR, but the panel felt it important to use this opportunity to improve police and mental health liaison.

68. The issue of mental health was raised at John's trial. The defence represented that John had a schizotypal personality disorder and alcohol dependency syndrome; this was countered by prosecution stating that intoxication played a bigger part

than any disorder. This supported the CIAT assessment made immediately after the homicide.

69. Support Services

70. Domestic violence support for this area is provided by Letgo Impact Housing. There are no records of contact from any parties subject of this report in Letgo case management or MARAC files. Letgo also provide DV training for GPs in the Cumbria region.

71. Substance Misuse

72. The issue of substance misuse is a recurring concern in this review and it was a key factor in the homicide and the criminal trial. John was found to be intoxicated on his arrest and had reported that he had been alcohol dependent for a long period.

73. John had never been formally referred to statutory health providers for treatment of his alcohol misuse. He had been provided with advice on how to self-refer to third sector agencies, but he did not take up this advice.

74. It is not known what effect any prescribed treatment could have had on the behaviour of John, it is apparent that the offer of self-referral did not work. A more robust referral process between GP, alcohol misuse providers may have compelled him to take up the treatment.

75. A culture of questioning

76. There are a number of occasions when agencies came into contact with the family and the circumstances were such that questions should have been asked about the domestic environment. Incidents where John's behaviour and alcohol consumption came to attention could have been examined to ascertain what effect this was having on domestic relationships.

77. The need to ensure that relationships are safe and healthy must be considered as a priority. There should be training to support a culture of questioning and establishing healthy relationships.

78. Policies and processes

79. It appears that existing policies and processes are in place within agencies to support the identification and prevention of DV.

80. In relation to substance misuse the established referral pathway from GP to NHS services was not followed, relying on patients self-referring to third sector agencies.

81. Family contact

82. The guidance for DHRs recommends that families and friends should be a part of the DHR. In this case the chair spoke to the victim's daughter, Claire. She provided valuable information to the panel that was not revealed during the IMR process.

83. Claire recounted that her mother was well integrated with the local community, but kept family relationships private. She was very worried about her brother's behaviour but could not convince her mother to share her concerns. After Claire reported John's behaviour to police, her mother was more supportive of her son. She was determined to keep family matters private. Claire told her mother that she was likely to be a target of John's aggression.

84. Sarah seemed determined to support her son through his alcohol dependency. It was revealed that, on the day before her death, she had booked an appointment for John to attend a private residential alcohol rehabilitation centre.

85. Claire did not believe that agencies could have predicted her mother's death or done anything effective to prevent it.

86. Equality and diversity

87. The victim was 77 years old at the time of her death, fit and healthy with only minor conditions being reported. Although she lived in an isolated area, she had no mobility issues. Sarah had her daughter living at the same property but no immediate neighbours.

88. Age UK have taken steps, outside this review process, to engage with issues of DV. It has been agreed that a member of Age UK village agent teams would be involved in Multi-Agency Risk Assessment Conferences (MARAC) discussions, to enable better understanding of issues affecting this area including.

89. One consideration mentioned throughout this report is the isolated geographical location of this family in the community. Any interaction with agencies mentioned within this report happened as a result of a member of the family visiting those services or requesting police attendance at the address. The remote location of this family would not bring them into contact with close neighbours able to report their concerns.

Conclusions

90. The issue of preventability

91. Whilst this review has shown that agencies have generally followed policies in relation to their internal working relationships, it has demonstrated that the dynamics of intimate relationships were not effectively explored.

92. One factor in this case has been the failure to refer John to appropriate NHS substance misuse providers. It is not believed that Sarah's death could have been prevented, but the lack of communication between agencies meant that the risks apparent now were not recognised and managed.

93. The IMRs across statutory agencies highlight some failings but not of sufficient gravity to indicate that Sarah's death could have been avoided. Consideration needs to be given to how information is passed between third-sector agencies and statutory agencies.

94. For these reasons it is important to test the performance of the agencies working individually and together to satisfy the partnership that things have improved.

95. Agencies must consider the affect of substance misuse on the perpetrator in DV cases with a view to understanding the dynamics and the possible indicators of abusive behaviour. The contribution of the victim's family has provided a valuable insight. It appears that the referral of John to a private rehab centre immediately before her death could have heightened tensions within the home. This emphasises the need to safeguard effective partnerships across statutory services, third sector agencies; engaging with families to identify and respond to risks.

96. This case highlighted that DV is present in all communities, urban and rural, and that consideration be given to the needs families in more isolated communities. The review did not reveal a failure to deal with long standing reported issues of DV, it highlights the need to maintain a dynamic view of potential risks to all members of a family and in particular those vulnerable through age. The scale and threat of DV is known to all statutory agencies and they have processes in place to address the obvious risks. If agencies consider the dynamics of personal relationships and the increased risk of DV when there is substance misuse, then future cases could be managed to a more positive conclusion.