Sunderland Partnership

Domestic Homicide Review

‘Derek’

January 2021

Final Draft

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Section 1: Introduction

1.1 This is a Domestic Homicide Review conducted under the mandatory requirements of the Domestic Violence, Crime and Victims Act 2004. It follows the death of a male in Sunderland in January 2021. The perpetrator was his adult son who was subsequently convicted of the manslaughter of his father.

1.2 The review examines agency responses and support given to the victim prior to his death in January 2021. It will also consider the actions and decision-making of professionals regarding their contact with the perpetrator.

1.3 In addition to agency involvement the review will examine the past, to identify any relevant background or potential abuse before the homicide, whether support was accessed and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify lessons that can be learned from this tragic incident.

1.4 The circumstances of the death were initially provided by Northumbria Police to the Chair of the Safer Sunderland Partnership by formal letter on 27th May 2021.

1.5 To protect the identity of those involved, pseudonyms were used for both subjects in the review. The victim will be referred to throughout as 'Derek'. The perpetrator will be referred to as 'Keith'. Keith is Derek's adult son.

1.6 The review will consider all agency contact / involvement with Derek and Keith from 24th December 2015 through to the date of Derek's death (a five year timeframe). However, the panel agreed that if further relevant information were discovered from before those dates then this would also be included in their chronologies and considerations.

1.7 The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

Section 2: Timescales

2.1 The review began on 27th July 2021 with the appointment of an Independent Chair and Author. The first DHR panel meeting was held on 16th September 2021. This was convened remotely due to the restrictions in place with the COVID-19 pandemic. The panel met again on 6th January and 3rd March 2022. The Review was concluded in May 2022.

2.2 The DHR was not adversely affected by the COVID-19 pandemic. However, although many restrictions had eased, panels were held remotely. They still gave the opportunity for valuable and constructive dialogue and challenge. Additional time was allocated to professionals who had extra responsibilities and pressures stemming from a backlog of work during the crisis.

Section 3: Confidentiality

3.1 The content and findings of this review will be 'confidential', with information available only to those participating officers and professionals and where appropriate their organisational management. It will remain confidential until the review has been approved for publication by the Home Office Quality Assurance Panel.

3.2 The victim, Derek, was 77 years old at the time of his death. His son, the perpetrator, Keith, was 43 years old at that time. They were both British citizens residing permanently in the UK. Their ethnicity is white / British.

Section 4: Terms of Reference

4.1 The terms of reference were agreed at the convening of the first DHR panel:

- Were practitioners sensitive to the needs of the victim and the perpetrator? Were they knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim or perpetrator?

- Did the agency have policies and procedures in place relating to domestic abuse? Were risk assessment and risk management processes for domestic abuse victims or perpetrators correctly used in this case?

- Did the agency comply with domestic violence and abuse protocols agreed with other agencies including any information sharing protocols?

- What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

- Were there any opportunities for professionals to raise safeguarding concerns in relation to the perpetrator's parents?

- When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?

- What information was known about the perpetrator? How accessible were services?

- Was the perpetrator subject to MAPPA, MATAC or any other perpetrator intervention programme? Were there any injunctions or protection orders in place?

  MAPPA is the Multi-Agency Public Protection Arrangements. These are statutory processes to manage sexual and violent offenders. The 'Responsible Authorities' (police, National Probation Service and HM Prison Service) all have statutory responsibilities to protect the public under national MAPPA guidelines).

MATAC is Multi-Agency Tasking and Coordination. It is a scheme currently being rolled out in many areas across the UK to specifically manage serial and repeat perpetrators of domestic abuse

- Were senior managers of the agencies and professionals involved at the appropriate points?

- Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?

- Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?

- Did any restructuring during the period under review have any impact on the quality of service delivered? How did the onset of the COVID-19 pandemic affect service delivery?

Section 5: Methodology

5.1 The decision to undertake a Domestic Homicide Review was taken by the Chair of the Sunderland Partnership on 20th May 2021. This followed detailed debate and consultation with all relevant partner agencies.

5.2 The aim of the DHR panel was to deliver the review as soon as practicable. The criminal trial process had already concluded prior to the start of the Domestic Homicide Review. The DHR panel Chair is confident the review maintained focus and the final report was completed in good time.

5.3 A Community Safety Partnership (CSP) has a statutory duty to enquire about the death of a person where domestic abuse forms the background to the homicide and to determine whether a review is required. In accordance with the provisions of Section 9 of the Domestic Violence, Crime and Victims Act 2004 (amended 2013), a Domestic Homicide Review should be:

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

a) A person to whom he was related or with whom he was or had been in an intimate personal relationship, or

b) A member of the same household as himself."

5.4 For this review, the term domestic abuse is in accordance with the agreed cross-government definition of domestic abuse:

"Any incident or pattern of incidents of controlling, coercive or 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. This can encompass but is not limited to the following types of abuse:

- *Psychological*
- *Physical*
- *Sexual*
- *Financial*
- *Emotional*
- *Coercive control*

Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and

regulating their everyday behaviour. Coercive behaviour is an act or pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish or frighten their victim."

5.5 The overarching reason for the commission of this review is to identify what lessons can be learned regarding the way local professionals and organisations work individually and collectively to safeguard victims.

5.6 The Sunderland Partnership identified that in this case the death met the criteria of the Domestic Violence, Crime and Victims Act 2004 and commissioned a Domestic Homicide Review.

The statutory guidance states 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 upon and what is expected to change as a result.

- Apply those lessons to service responses including changes to policies and procedures as appropriate.

- Articulate life through the eyes of the victim, to understand the victim's reality; to identify any barriers the victim faced to reporting abuse and learning why interventions did not work for them.

- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter- agency working.

Initial scoping suggested that most agencies in Sunderland had limited involvement with both subjects of the review. Nevertheless, chronologies were requested and six organisations were required to submit an Individual Management Review of their agency's involvement.

From scoping exercises, it does not appear that the victim or perpetrator had any contact with support agencies outside the Sunderland area. However, the perpetrator did live elsewhere earlier in his life (linked to his employment). Therefore, enquiries were carried out with these employers in order to build a wider picture of his experiences.

Section 6: Involvement of family, friends, neighbours and wider community

6.1 The victim, Derek, lived at home with his wife. They have two grown up children; a son (the perpetrator) and an adult daughter. The perpetrator was living with his parents at the time of the attack which led to Derek's death.

6.2 The Independent Chair for the Domestic Homicide Review attempted to involve the family in the review. Both Derek's wife and his daughter declined to take part. They simply felt that the experience would be too upsetting and did not want to reopen matters or discuss any issues.

6.3 Initial contact was made via the police Family Liaison Officer (FLO) who had built up a relationship with them during the investigation and criminal trial process. At the Independent Chair's request, the FLO informed the family of the DHR process and that the Chair would like to speak with them. The family understood why a review was taking place but declined to be involved. The Chair wrote to Derek's wife and daughter; explaining the process in detail and highlighting how they, as the family, would add value to the review and in particular around learning from the tragedy. The family did not respond. A further telephone call was made by the FLO to ensure receipt of the letter. The family confirmed they had received the letter but repeated what they had previously told the Family Liaison Officer.

6.4 The perpetrator's sister was a witness to the attack. She provided the police with a witness statement and was prepared to give evidence about her father's death to the trial. This was not required after her brother pleaded guilty to manslaughter on the first day of the trial. Nevertheless, because she assisted the investigation, her mother will no longer speak to her. Sadly, Derek's wife has now lost her husband to a violent death, lost her son to a long term prison sentence for killing his father and lost contact with her daughter, as she did not agree with her daughter assisting the criminal investigation.

6.5 After two telephone calls from the FLO and letters directly from the Independent Chair, both Derek's daughter and his wife still declined to be involved in the Domestic Homicide Review. They were informed that if they ever changed their mind, they could contribute at any time. A direct contact number was provided. Unfortunately, neither has been in touch. We do not judge them for this and the review panel understand that this would be a painful process for them. But, after repeated attempts, we must respect their request for privacy and so the family were not involved in the review. There were no close friends of Derek who could assist with any further information about understanding his life or experiences.

6.6 Therefore the lens through which the DHR has tried to understand Derek's life is limited.

6.7 With family reluctance to be involved in the DHR process, other avenues were explored. Contact was made with the perpetrator's former employers. He was a professional footballer and played for several teams. He played professional football soon after leaving school for a Third Division club in the North-East of England. In 1996, aged only 18 years, he was signed by Sunderland F.C who were then playing in the English Premier League (i.e. the top tier of English football). However, he never played for the first team. The Independent Author contacted Sunderland F.C., but due to the time lapse, they were unable to give any specific details of why Keith was only retained by them for one season.

6.8 From Sunderland F.C., Keith transferred to a lower league club (in the Third Division) in 1997 but was still playing football as a professional career. The Independent Author has spoken at length to staff at this club. They do recall Keith. He was a 'big money' signing (from a Premier League club). There was excitement in the local town as he was a talented player. Unfortunately, Keith did not reach his potential. He was part of a group of four or five players known within the club as the 'Tuesday Club'. Back in the 1990s there was widely publicised problems across the game of professional football with a drinking culture. However, this 'Tuesday Club' were known to drink to excess. They finished training at lunchtime on a Tuesday and had the rest of the day to themselves plus Wednesday was their day off. The group would head straight to the local pubs and drink all day and evening, before going home to sleep until late into the next day. Despite the drinking culture in football at that time, it should be noted that most of the players did not drink to excess. It was a minority.

6.9 The staff believe Keith never 'invested' in their club. It was a small town but had committed supporters who attended regularly and cared passionately about their football club. Many players involved themselves in the local community as role models. Keith did not. He would leave the area as soon as he finished playing on a Saturday. He would travel back home to his native Sunderland where it was known he would again be drinking to excess. After one year, his contract was not renewed. He simply was not putting in the effort to make it as a professional sportsman.

6.10 Several years later (in 2004), Keith was playing Sunday league football. During a match, he assaulted the referee. He was banned by the Durham FA for an indefinite period and fined £250.00. Violence and alcohol abuse were longstanding issues for Keith.

Section 7: Contributors to the Review

7.1 Six agencies have contributed to the Domestic Homicide Review by the provision of reports and chronologies. Individual Management Reviews (IMRs) have been requested and provided. The review chair and panel agreed that reports, chronologies, IMRs and other supplementary details would form the basis of the information provided for the overview report author.

7.2 The following organisations were required to produce an Individual Management Review:

- Sunderland Clinical Commissioning Group
- National Probation Service
- Northumbria Police
- North-East Ambulance Service
- Cumbria, Northumbria, Tyne & Wear NHS Foundation Trust
- South Tyneside and Sunderland NHS Foundation Trust

Three of the perpetrator's former employers were also contacted as part of the review process. Additional information about his professional football career was provided and included in this report.

In addition, expert advice and oversight was proactively sought. This resulted in two additional organisations agreeing to be part of the process and make comment within their area of expertise:

- 'Wearside Women in Need' (domestic abuse support service)
- 'Change, Grow, Live' (substance misuse support service)

Section 8: The Review Panel Members

8.1 The Chair of the Review Panel is Mr Mike Cane. He is also the appointed Independent Author for the review.

8.2 The Domestic Homicide Review panel is comprised of the following people:

- Mike Cane - Independent Chair and Author
- Wendy Proctor, Designated Nurse, Safeguarding Adults, Sunderland Clinical Commissioning Group
- Dr Chandra Anand, Named GP, Safeguarding Adults, Sunderland Clinical Commissioning Group
- Detective Chief Inspector Shelley Hudson, Safeguarding (South), Northumbria Police
- Stephen Laverton, Strategic Manager, Community Safety & Safeguarding, Sunderland City Council
- Gary Connor, Head of Probation Delivery Unit, Sunderland
- Becky Rogerson, Chief Executive, 'Wearside Women in Need' (from 2nd panel)
- Jane Stubbings, Named Safeguarding Lead, North-East Ambulance Service
- Sheona Duffy, Acting Team Manager, Named Nurse, Safeguarding and Public Protection, Cumbria, Northumbria, Tyne & Wear NHS Foundation Trust
- Tracy Dawson, Named Nurse, Safeguarding Adults, South Tyneside and Sunderland NHS Foundation Trust
- Ashleigh Scott, 'Change, Grow, Live' (from 2nd panel)

All panel members were completely independent. None had any direct dealings with the subjects of the review nor had management responsibilities to any front line worker involved with any of the subjects.

During the first DHR panel meeting, a decision was made to invite a specialist IDVA service to join the panel. This was important when considering this domestic homicide was a close family relationship (i.e. father and adult son) rather than an intimate personal relationship. An agency, not from an organisation involved with the subjects of the review, could provide additional insight from a victim's perspective.

Following submission and collation of the IMRs, the Independent Chair noted a significant emerging theme was misuse of alcohol. Therefore, an organisation specialising in alcohol and substance misuse was contacted and agreed to join the process from the 2nd DHR panel.

Section 9: Author of the overview report

9.1 The appointed Independent Author is Mr Mike Cane of MJC Safeguarding Consultancy Ltd. He is completely independent of the Sunderland Partnership and has no connection to any of the organisations involved in the review. He is a former senior police officer where his responsibilities included homicide investigation, safeguarding and investigation of child abuse, rape & other serious sexual offences and abuse of vulnerable adults. He has extensive experience as an author and panel member for Domestic Homicide Reviews and is a former member of a Safeguarding Vulnerable Adult Board, several Domestic Abuse Strategic Partnerships and a number of Local Safeguarding Children Boards. During his police career he was Force lead for domestic abuse, child protection and vulnerable adults. He chaired the MARAC meetings across four Local Authority areas for several years. He has previous experience of conducting Domestic Homicide Reviews, Safeguarding Adult Reviews and Child Safeguarding Practice Reviews as both an Independent Chair and Independent Author.

Mike has completed DHR training for Chairs in 2010 and refresher training in 2017. He attended AAFDA (Advocacy After Fatal Domestic Abuse) conferences in 2018 and 2019 as well as AAFDA training on 'involving children in DHRs' in 2021. He has also designed and delivered domestic abuse training (identification, risk assessment and risk management) to staff across the public and voluntary sector.

Section 10: Parallel Reviews

10.1 The inquest into Derek's death was commenced and then adjourned pending the criminal trial process.

10.2 There were no children involved in the review process and so no requirements for any consideration of a Child Safeguarding Practice Review. The perpetrator does have children from previous relationships but they did not live with him. No children were present during any incidents prior to the tragic event that led to the victim's death. On that occasion, they were Keith's sister's children; they were safeguarded by their mother and removed from the scene.

10.3 None of the subjects of the Domestic Homicide Review had been assessed nor were in receipt of services, under the Care Act 2014 and so there was no requirement for a Safeguarding Adult Review. However, the completed DHR, including conclusions and recommendations, will be shared with the Safeguarding Adult Board for Sunderland.

Section 11: Equality and Diversity

11.1 The protected characteristics named under the Equality Act 2010 are age, sex, gender reassignment, marital status, race, religion/belief, pregnancy, sexual orientation and disability.

11.2 The victim was married at the time of his death. Their marital status does not seem to have affected any of the services provided.

11.3 No issues were identified during this review applicable to sex, gender reassignment, race or religion.

11.4 Neither the victim nor the perpetrator were recorded with any disability. Although Keith received treatment for alcohol dependency, he was not registered with a disability.

Section 12: Dissemination

12.1 The following organisations will receive a copy of the report after any amendment following the Home Office's quality assurance process.

- The perpetrator's Offender Managers, National Probation Service.
- All organisations within the Sunderland Partnership.
- The Sunderland Safeguarding Adults Board
- The DHR panel for Sunderland
- The Home Office DHR team
- Office of Police and Crime Commissioner for Northumbria

Section 13: Background Information (the facts)

Case specific background

13.1 The victim, Derek, was born in 1943 in the UK. He was married for many years and he and his wife had two children, a son and a daughter. He was 77 years old at the time of his death. He had worked as a jockey prior to his retirement but he was still working part time running a local taxi / private hire firm. He had some health issues but was not in particularly poor health for a man of his age. Derek was very engaged with his GP Practice and had regular contact with his GP and other medical support services.

13.2 The perpetrator, Keith, was born in 1978 in the UK. He was 42 years old on the day of the incident that led to his father's death. He had accessed a number of services over many years linked to alcohol dependency. He also had contact with police and probation services. He was living at his parent's home at the time he killed his father. He had lived with them throughout the pandemic, having previously separated from his partner following domestic abuse.

13.3 Keith's relationship with his sister was strained. He had previously rented a property from her but there had been a dispute over payments and the police were involved.

13.4 On Christmas Eve 2020, Keith's sister arrived at her parent's home in Sunderland to spend Christmas with them. She had her two young children with her. The sister had no idea Keith was staying there and the visit was made on the understanding that Keith would not be present. His sister was worried about his drunkenness in front of her children. While she was unpacking her belongings from the car, the elder of her children went upstairs then came straight back down and said, "There is a man upstairs." This was her brother, Keith. She then began to collect her things and took hold of her children to get back in the car to leave. Her father, Derek, said "I'm sick of this."

13.5 Keith was on his way downstairs at this point. He knocked his father to the floor and began punching and throttling him. Keith's sister telephoned the police and Keith was arrested at the scene. His father was still conscious but was dazed. Derek initially declined to go in an ambulance. However, he subsequently did go to hospital with a suspected bleed on the brain. Sadly, he died in hospital a few weeks later, in January 2021.

13.6 Keith was charged and a trial date listed. He appeared at Newcastle Crown Court in May 2021 but pleaded guilty to manslaughter on the opening day. Sentencing was adjourned for reports. In July 2021 Keith appeared at Newcastle Crown Court and was sentenced to 11 years and 10 months imprisonment for the manslaughter of his father.

Section 14: Chronology

14.1 The agreed date parameters established by the DHR panel were from 24th December 2015 through to Derek's tragic death in January 2021. This meant agencies were required to note all interactions with professionals going back five years from the incident on Christmas Eve in 2020. However, there was a caveat that *any* incident or pattern of contacts before that date should also be considered if the IMR author believed it may be relevant and may assist in developing knowledge and learning from this review.

14.2 The first entry to note within agency records occurred on 23rd December 1990. As the incident is over 30 years ago there are only brief details available. The incident related to domestic abuse. Derek (the victim of this domestic homicide) was accompanied to hospital in Sunderland by police as he was detained for an assault. The police or hospital notes do not elaborate further but the incident is 'coded' as domestic abuse. We cannot ascertain who was the victim.

14.3 There was a domestic abuse incident between the victim and the perpetrator attended by Northumbria Police many years before the parameters set by the DHR panel. On 19th November 2001 police received a call from Derek stating he had been assaulted by his 23 year old son and that his son was still in the house. The notes state 'both parties had consumed quite a bit of alcohol.' Derek had suffered a split upper and lower lip. Keith was arrested. Derek gave a retraction statement and no charges were brought against Keith. Keith had also received a split lip and grazed eye during the incident. Keith was processed by way of a breach of the peace. No crime was recorded for the incident.

14.4 Between 2006 and 2013, Keith was dealt with by police having been named as the perpetrator at several domestic abuse incidents with his ex-partner (wife). He was issued with a restraining order to protect the victim (he breached the order and received a further restraining order at Sunderland Magistrate's Court in June 2014).

14.5 On 22nd September 2013. Keith attended the Emergency Department at Sunderland Hospital. He stated he was under a lot of stress and was going through a divorce. There was mention of his excessive alcohol use and he was advised to reduce his intake. Keith was discharged from the hospital with a GP follow-up.

14.6 Keith was named as a perpetrator of domestic abuse with another partner at an incident attended by police in May 2016. This partner was a separate victim to his ex-wife. He had grabbed her by the neck. Keith had left before the police arrived. His partner declined to engage with officers and no further action was taken.

14.7 Although Derek was in reasonably good health for a man of his age and he attended his annual health checks, there is an entry on 15th December 2016 when his wife dialled '999' for an ambulance after he was vomiting and had chest pains. When the ambulance crew attended, Derek declined to go with them to hospital stating he would prefer to contact his own GP the following morning.

14.8 On 11th September 2017, Keith's mother dialled '999' for an ambulance for him. He was suffering chest pain and a shortness of breath. The ambulance took him to Sunderland Royal Hospital Emergency Department. Keith informed staff he had taken cocaine at the weekend during a night out. He told them he hadn't done this since he was in his 20s. His chest x-ray showed nothing abnormal and he was discharged. He was advised to see his own GP regarding anxiety symptoms and to stop using cocaine.

14.9 Keith had two more appointments at his GP practice in September 2017. On 21st September he was advised by the Practice Nurse about alcohol and safe drinking limits. The following day he discussed his panic attack with his GP that led to his attendance at the Emergency Department at hospital. The GP also noted he was an ex-professional footballer and was now working as a car salesman. He also disclosed his relationship had broken down with his partner.

14.10 Derek had five medical contacts during 2018. His annual routine hypertension review was on 17th January. All appeared fine. However, on 27th January he was taken to Sunderland Royal Hospital Emergency Department with numbness and weakness to his right arm. He had a CT scan and stayed overnight for an MRI scan. However, Derek declined to be admitted, stating he preferred the option of an outpatient's clinic. The MRI scan showed a tiny focal acute infarction in the left frontal lobe (blockage in the blood vessel that impedes blood flow). He reattended hospital on 9th February for an echocardiogram and again on 12th February for a 'doppler' ultrasound of the carotid arteries. This showed some thickening but no narrowing. Derek had no further medical intervention until 23rd November 2018 which was for his routine annual hypertension review.

14.11 Keith had two GP appointments in 2018. Both were related to panic attacks. On 10th April, he stated he had an attack while driving. He disclosed to the clinician that he was having a difficult period at work. He had gone out 'binge drinking' at the weekend. He was scared of being alone at home. He said he had no suicidal thoughts or thoughts of self-harm. The GP noted Keith to be anxious but had a good rapport. He was prescribed sertraline and propranolol. Medical advice is not to drink alcohol when taking this medication (sertraline has a sedative effect. Propranolol lowers the blood pressure and heart rates to calm anxiety).

14.12 Keith's second GP appointment was on 8th May. Again, his issue was panic attacks. Keith informed the doctor he felt the medication had helped, but he had run out at the weekend and now felt worse. He again stated he was

under pressure at work. He admitted to excessive alcohol use. He was provided with a contact number so he could self-refer to a local substance misuse support group 'Wear Recovery'. A triage worker from Wear Recovery telephoned Keith on 15th May but he was at work and couldn't talk. The worker rang back the following day. Keith asked for help around his current alcohol use. He stated he consumed two bottles of wine every evening and that he had done so for several years. He was divorced and living alone in a private rented property. A goal was set for him to achieve abstinence. A full induction appointment was offered to Keith for 23rd May but he did not attend. Another date was offered but he did not attend that appointment either. When he did not attend his 3rd offer of an appointment, a discharge letter from the service was sent.

14.13 It was a year later, on 10th June 2019 when Keith had his next GP appointment. He was suffering low mood after the death of a close friend. He was anxious and was not sleeping. He was given a 'fit note' for three weeks, prescribed 50mg sertraline once a day and 3 x 10mg tablets of propranolol per day.

14.14 Police were called to seven separate domestic abuse incidents between Keith and his partner in 2019. This was a separate female to his previous two female victims. A summary of each incident gives an insight into the nature of the abuse:

- 13th August; went to his ex-partner's home after their break-up and began a tirade of verbal abuse. He then left but sent several text messages making threats to damage her property. While the ex-partner was out of the house, a downstairs window was smashed but there was no direct evidence to link Keith to the damage. The ex-partner refused to provide any kind of witness statement.

- 18th August; an argument developed inside a public house. Keith's ex-partner then punched him in the back of the head four times. Keith telephone the police but he had gone before police arrived. His mother advised officers that he no longer wished to make a complaint.

- 16th October; Keith contacted police to say that his ex-partner had punched him and spat at him. The incident took place inside her home. There were no visible injuries. Keith provided a statement and his ex-partner was interviewed under caution. She made a counter allegation about him assaulting her son but the son would not provide police with a statement. No further action was taken against either party.

- 2nd November; Having been in an 'on / off' relationship for several weeks, Keith's partner finally had ended the relationship. He attended her address intoxicated and wanted to stay. She refused so he began kicking at the front door and shouting in the street. He had left before police arrived. She declined to provide police with a witness statement as she did not want to inflame the matter.

- 3rd November; Keith's ex-partner telephoned police to report he had attended that morning to collect his things. When she told him there were none of his belongings at the house, he grabbed her by the neck and spat in her face. He was later arrested but there was insufficient evidence to charge him and he was released. His ex-partner consented to a referral to IDVA services. She declined to go to a refuge and confirmed he did not have a key to the property. She was encouraged to report any further incidents and block his number on her phone.

- 4th November; Keith's ex-partner reported he had followed her after she picked her child up from school. He approached her inside a supermarket. She contacted police and he left. She then disclosed that after Keith had been released from police custody the previous day he had sent her four text messages and tried to call her 31 times. His ex-partner did provide a witness statement. He was then traced, arrested and charged with common assault, public order offences and harassment. He was remanded in custody and appeared at court the next day where he pleaded guilty. He was sentenced on 6th November.

- 7th November; Keith reported that his ex-partner was telephoning him from a withheld number and was abusive during the call. In another call he reported she had attended his home and thrown his belongings on the driveway. Police attended but Keith did not want any further action taken.

14.15 On 12th November 2019, Keith had his first appointment with his probation officer (relating to his conviction on 6th November). He was sentenced to an 18 month Community Order. The order had two requirements; complete a Building Better Relationships (BBR) programme and 15 days Rehabilitation Activity Requirement (RAR).

14.16 On 13th November a MARAC (*Multi Agency Risk Assessment Conference)* convened to discuss the case of Keith and his ex-partner. A MARAC discusses those domestic abuse cases which are assessed as the highest risk incidents. The action from the MARAC was to refer Keith to the MATAC programme (*MATAC is Multi Agency Tasking and Coordination).* This forum manages serial perpetrators of domestic abuse.

14.17 On 27th November 2019, Keith again had a face to face appointment with his probation officer. The officer completed an interview ready for the completion of the Initial Sentence Plan and to start the Community Order.

14.18 Their next appointment was on 3rd December when Keith and his probation officer discussed Keith's alcohol use and his relationship with his ex-partner.

14.19 A week later, at the next appointment with the probation service on 10th December, Keith discussed his restraining order. Keith also disclosed he was living with his parents and he was consuming a bottle of wine every night. He stated this was less than if he was not living with his parents.

14.20 At Keith's probation appointment on 17th December they recapped on current issues and progress. Likewise, there were no new issues discussed a week later on 27th December.

14.21 On 3rd January 2020, Keith rang the probation officer to advise he was unwell and could not make their scheduled appointment. These reasons were accepted by the probation officer.

14.22 On 5th January 2020, Keith's mother telephoned the non-emergency NHS number to report Keith was threatening suicide. Keith came on the line and stated he was fine. He said he was not feeling suicidal but had done so in the past. Keith was not willing to continue the conversation and so an assessment could not be completed. When staff rang back, Keith was apparently asleep and his mother stated she was happy to ring back if she had any concerns.

14.23 On 10th January 2020, Keith attended his scheduled appointment with his probation officer. They discussed the forthcoming BBR programme. Another appointment on 14th January involved discussions about Keith's apparent reduced drinking levels. Further appointments took place with his probation officer on 23rd January, 30th January, 3rd February, 13th February, 20th February and 27th February.

14.24 On 9th March 2020 Keith was arrested for drink driving. He had crashed into another vehicle, ran off and was found hiding nearby. He was injured and so taken to hospital. Subsequent breathalyser enquiries showed him to be above the legal drink-drive limit. This information was not shared with the Probation Service at this point.

14.25 On 3rd April 2020, Keith was contacted by his probation officer on the telephone (COVID-19 lockdown was now in place). Keith confirmed he was still living with his parents. He stated he was not drinking and could not work due to the COVID lockdown. He was advised he should have informed the Probation Service of the incident in early March and especially as there was police involvement.

14.26 On 20th April 2020, Keith's probation officer carried out a 'structured interview' on the telephone with Keith. He indicated to his probation officer he was not guilty of the alleged drink driving offence in March. A further telephone interview took place on 4th May with probation programmes staff. Keith told the programmes staff he had been involved in a car accident. A further call took place with the programmes staff on 11th May.

14.27 On 13th May 2020, Keith had a GP telephone appointment. He said he had been in low mood for years, looking after his 94 year old grandmother. He had not been sleeping and was drinking excessive amounts of wine at night. This information was shared with the Crisis team on 14th May. The same day, Keith's mother telephoned the Initial Response Service at CNTW. She informed professionals that she had concerns over her son's mental health. She stated he was an alcoholic who had been drinking since

the break-up with his partner. She went on to inform the clinician that Keith believed he had been hearing voices telling him to kill someone. The comments were further explored during the call. His mother believed this may be Keith's own thoughts due to his level of distress. He had not threatened any individual nor reported any plans to do the same.

14.28 On 16th May 2020, Keith attended Sunderland Royal Hospital feeling unwell. He told staff at the hospital he had started on some new medications from his GP and that they were making him feel 'off his head'. He was advised to stop taking the medication and seek a review with his GP.

14.29 On 17th May, Keith self-referred to the Initial Response Service (IRS) and a telephone triage was completed with him. The referral was then closed. Keith rang the IRS again the following day. The details of the triage were then shared with Keith's GP.

14.30 On 26th May an unplanned telephone meeting took place between Keith and his probation officer. There is nothing significant recorded in the notes. He was also contacted by the programmes staff later that day.

14.31 On 1st June 2020, the programme delivery team (managing Keith's activities on his community order) rang Keith. The staff member believed Keith sounded intoxicated and he confirmed he had drunk a bottle of wine in the garden before the telephone call. Keith told the member of staff that the victim of his index offence (i.e. his ex-partner) had been texting him and he wanted advice if he was in breach of his restraining order if he replied.

14.32 On 3rd June 2020, a friend of Keith contacted the CNTW Initial Response Service to tell them she had found Keith drunk in a field and he had drunk 50 units of alcohol. The friend was provided with a telephone number for 'Wear Recovery'.

14.33 During a telephone call with a member of his programme team on 3rd June, the staff member noted that Keith was intoxicated and appeared to have relapsed. Keith said there is nothing the alcohol support service can do for him and that his parents are not happy about his behaviour. This information was shared with Keith's probation officer.

14.34 On 8th June, during a telephone call, Keith stated to the programme team member that he was 'back on the straight and narrow' as he had reduced his alcohol consumption.

14.35 On 10th June 2020, a worker from 'Wear Recovery' (a specialist addiction support service working under the management of CNTW) conducted a triage assessment with Keith. Their notes of the discussion give further details:

Keith reports to drinking 2 to 3 bottles of wine daily for approx. 15 years. Recent break up with partner as well as losing his job, increased alcohol since.

Self-employed for roofing company (pandemic has stopped his current employment- furloughed)

Keith informed he is a perpetrator of DA and is under a community order with a BBR requirement. 10 months left on order and has a Probation Officer

ALCOHOL AUDIT Score: 36

Denies any mental health issues. Is not taking recently prescribed meds from GP as does not want to become addicted.

Currently residing with parents

The outcome of the meeting was for Keith to be offered a 'Humankind' telephone assessment appointment and to access support from 'Wear Recovery' due to his history and current issues with alcohol and the high score on the alcohol audit. The professional recorded that Keith was presently exceeding the threshold for suitability for treatment (the threshold is a 'score' of 16 and above). Once Keith was ready for treatment, this could include psycho-social intervention groups and motivational interviewing. He could also be signposted to services such as harm reduction advice.

14.36 On 15th June, five days after the triage, Keith was given an initial comprehensive assessment by Wear Recovery:

Reports to have reduced alcohol use over the past seven days. Reports historic heavy alcohol use of 16-18 years drinking approx. 2 or 3 bottles of wine on a nightly basis.

Reported withdrawal symptoms of shakes and sweats.

No current issues with physical health.

Reports recent crisis team contact however denies current suicidal ideation at time of assessment.

Discussed treatment options and Keith would be interested in acamprosate (this is a medication to reduce cravings for alcohol).

The same day, Keith spoke on the telephone to probation programmes staff to indicate he was engaging with Wear Recovery, had been alcohol free for seven days and due back at work the following day.

14.37 On 22nd June 2020, there was a telephone call between Keith and a programme staff member working on the delivery of Keith's probation requirements. Keith reported to the professional that he had no further alcohol use and was intending to return to work shortly.

14.38 On 29th June, Keith had a (telephone) meeting with an assessment and engagement worker at CNTW. Keith stated he had lost a friend to alcohol last year and so for this reason had not drunk for the last three weeks. He stated he was physically and mentally well and requested support with maintaining his abstinence. No withdrawal symptoms were noted by the professional.

14.39 On the same day as his discussion with staff at CNTW, Keith also had a telephone appointment with his probation officer. They discussed his alcohol reduction and Keith said he felt better now he had returned to work. There also appears to have been a third telephone conversation between Keith and a professional that day. The third call was with a programme staff member and again they talked about him not now consuming alcohol and returning to work.

14.40 On 6th July, there was a telephone meeting between an assessment and engagement worker at CNTW and Keith. He reported four weeks abstinence and apparently 'felt great within himself'. He said his next goal was to achieve a further month of abstinence - taking him to two months alcohol free. He has had some cravings but was using distraction techniques. He went on to say working was also helping.

14.41 On 13th July, Keith had a brief update call with the programmes team as a member of staff would be on leave at their next scheduled catch up. The date was rearranged.

14.42 A week later, on 20th July, there was a further telephone meeting between Keith and his recovery worker. He stated his recovery was going well and he had not taken any alcohol for six weeks. He had planned to go to a pub with friends (now that lockdown measures had eased) but then cancelled this arrangement.

14.43 On 6th August 2020, Keith's probation officer tried to contact him for a telephone appointment. There was no reply. This attempt was three weeks after his last telephone appointment with the Probation Service.

14.44 However, on 10th August, a staff member from the 'Accredited Programmes Unit' did speak with Keith (this is a team employed by the Community Rehabilitation Company – since re-organised as the Probation Service - delivering towards Keith's Community Order). He was informed he had been selected to re start the group work from September. In line with the Exceptional Delivery Model in place (due to Covid-19 restrictions) this involved three men (including Keith) working with two tutors.

14.45 On 11th August 2020, Derek attended his GP. He reported tiredness and weight loss. He had blood tests and was referred for a chest x-ray. The blood tests were normal. His chest x-ray was carried out at Sunderland Hospital on 18th August. Both lungs were clear.

14.46 On 12th August, during a telephone appointment with CNTW, Keith reported he has continued to maintain abstinence and was feeling well within himself. He said he had no concerns at present. However, he stated he has occasionally experienced cravings but has managed to distract himself well and has maintained abstinence.

14.47 On 20th August 2020, Keith had another telephone appointment with his probation officer who reviewed progress and did not consider a referral to alcohol services was necessary at that point.

14.48 On 23rd August 2020, Keith's ex-partner called police. She reported they had temporarily been living together again but had an argument. He had left but returned in the early hours, punched her and then punched her 16 year old son who tried to intervene. Keith was arrested but his ex-partner would not assist the investigation and her son said it had all been a mistake. With no statements provided, no further action was taken. (The Probation Service were not informed of the incident until 15th September).

14.49 On 27th August, staff at CNTW were unable to get a reply on the telephone from Keith. A message was left on his answerphone offering a further appointment on 9th September. (This appointment also received no reply and another appointment was offered for 22nd September).

14.50 On 8th September 2020, Keith failed to keep both his telephone appointment with his probation officer or attend his programme session. An enforcement letter was sent out on 11th September.

14.51 On 17th September Keith contacted his programme team to inform them he was at court (he had voluntarily surrendered to custody for outstanding matters). He was asking to re-join the group. During a further call on 21st September, he stated that he would complete a course to reduce the driving disqualification to 9 months and that he was employing a driver so that he can still work. He said that he was not in the area at the time of the recent assault allegation against his ex-partner and her son. He raised concerns about COVID and passing that on to parents and grandparents, should he attend an office.

14.52 On 22nd September 2020, Keith had a planned telephone call with an assessment and engagement worker from CNTW. The notes record that Keith did not appear to be under the influence of alcohol.

14.53 On 1st October 2020, Keith had a telephone appointment with his probation officer. He stated he was not misusing substances and was still living with his parents.

14.54 On 7th October during a telephone discussion with staff from CNTW, Keith reported he did have a drink on a weekend and said this 'didn't go so well'. Staff recorded that Keith knows he needs to be abstinent from alcohol and that he had self-reported he is alcohol free again.

14.55 On 22nd October 2020, Keith had another telephone appointment with his probation officer (staff were still working to an 'Exceptional Delivery Model; introduced during the Covid-19 'lockdown' when only urgent, complex cases were face to face. This was not a complex case). During their conversation they discussed issues such as what might reduce risk and what may increase risks.

14.56 On 29th October, Keith made allegations against his ex-partner; that she had assaulted him and threatened to kill him. His ex-partner was arrested and interviewed but denied any wrongdoing. She in turn made a counter allegation that Keith was harassing her. There were no independent witnesses and no further action was taken against either individual. As a result of these developments, Northumbria Police informed the Probation Service.

14.57 On 3rd November 2020, Derek contacted his GP. He had back pain following some horse riding. He was referred for an x-ray. The results of this were received on 22nd November. The disc spaces were preserved (intact) and there was no vertebral collapse. The Sunderland Hospital notes also state 'no safeguarding concerns raised.'

14.58 On 24th November 2020, Keith had a further telephone appointment with his probation officer. They discussed his recent 'domestic incidents'. A decision was made to start some 'one to one' work relating to domestic abuse.

14.59 On 15th December 2020, Keith had another telephone appointment with his probation officer. The discussion was around potential matters outstanding including possibly a warrant. The notes on this conversation do not give any further details.

14.60 On 17th December 2020 Keith had another telephone contact with his probation officer. This contact is recorded as a 'Programme 1-2-1 Session'. The probation officer discussed forthcoming in-depth work around domestic abuse. Keith is described as 'positive' and was sure he would not reoffend.

14.61 The telephone appointment with his probation officer was Keith's last appointment with professionals before the attack he carried out on his father one week later. CNTW staff did attempt to call Keith on 23rd December but did not get a reply. A letter was sent offering him an alternative appointment on 13th January 2021.

14.62 On Christmas Eve 2020, at 3.28pm, the North-East Ambulance Service received a '999' call to Derek's home address in Sunderland. The police were at the scene and reported Derek had been assaulted; punched

several times to head. He had dizziness, shortness of breath, nausea, an indication of blood coming from the ear (assessment showed a small cut) and vomiting blood. Derek was taken by ambulance to Sunderland Royal Hospital. His condition worsened and on 26th December he was taken to the Intensive Care Unit at the Royal Victoria Infirmary (RVI) in Newcastle.

14.63 Keith was arrested at the scene on 24th December. He was charged with attempted murder and appeared at before the next available court. He was remanded in custody awaiting his next court appearance.

14.64 Sadly, Derek died in hospital in late January 2021.

14.65 Keith appeared at Newcastle Crown Court in May 2021; he pleaded guilty to manslaughter on the opening day. Sentencing was adjourned for reports. In July 2021 Keith appeared at Newcastle Crown Court and was sentenced to 11 years and 10 months imprisonment for the manslaughter of his father.

Section 15: Overview

15.1 The detailed chronology charts the involvement of both Derek and Keith with a variety of agencies. Derek had sporadic contact, predominantly linked to health matters. It is reasonable to state that Derek was in fairly good health for a man of 77 years. He maintained an active life including running a business and enjoying hobbies (linked to his former profession) of horse riding. He lived at home with his wife. They had a long and stable marriage. Their son Keith had extensive contact with professionals for a variety of reasons.

15.2 Keith's loss of his career as a professional footballer had a major impact on his life. However, misuse of alcohol was clearly a factor even during his professional playing days.

15.3 The break-up of Keith's marriage and other relationships also affected him. Although he spent time renting a property on his own, Keith gravitated back to living at his parent's house.

15.4 Alcohol played a significant part in Keith's life. Alcohol is the major factor in his contact with the police, the Probation Service and a host of medical and support agencies.

15.5 Keith had been a perpetrator of domestic abuse with several partners and ex-partners. There was also a recorded violent domestic abuse incident between him and his father 19 years prior to the incident on 24th December 2020 which led to Derek's death and Keith's arrest and subsequent conviction for manslaughter.

15.6 The impact of the COVID-19 pandemic is clear to see from some of the agency records. This will be explored further in the analysis section of this review.

15.7 Agencies last had contact with Derek two months before the attack that led to his death. Keith was in contact with professionals right up to the week before the attack on his father. He was subject to a community order, supervised and managed by the Probation Service, at the time of the incident.

Section 16: Analysis

16.1 This was a case of a father killed by his adult son. The victim was elderly and had some health issues. However, he also still led an active life. His son lived at home with his parents at the time of the homicide.

16.2 This death was an 'Adult Family Homicide'. The majority of domestic homicides are 'intimate partner homicides'. Adult family homicides make up only 18% of all domestic homicides.[1] This low figure should, in itself, mean that organisations may need to reflect on their processes and practices and whether the issue should be highlighted as a concern to front line professionals.

16.3 Adult family homicides also feature more male victims (50% of deaths in comparison to intimate partner homicides where 27% of victims are male). Age is also worthy of note. In adult family homicides, 43% of victims are over 65 years of age.[2]

16.4 When closely examining data linked to risk factors, there are some concerning factors linked to Derek's death. Research has shown that the most common factors related to risks within adult family homicides[3] are:

- Mental Health (51% of all adult family homicides).
- Drug or alcohol misuse (50% of all adult family homicides).
- The perpetrator known for previous domestic abuse offending (45% of adult family homicides).

16.5 This analysis will examine how and why events occurred, decisions that were made, actions that were taken or not taken. To maintain focus, this will be done by addressing each of the terms of reference agreed by the Domestic Homicide Review panel.

16.6 **Were practitioners sensitive to the needs of the victim and the perpetrator? Were they knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim or perpetrator?**

16.6.1 There was a historic incident recorded by Northumbria Police of violence or domestic abuse being suffered by the victim. It is unclear which, if any, other agencies had knowledge of this incident which was an assault perpetrated by his son, Keith. The incident involved both men suffering split

[1] Vulnerability, Knowledge and Practice Programme
[2] 2020-21 Home Office, NPCC, CoP
[3]

lips and grazing to the face. Keith (who was 23 years old at the time) was arrested but not prosecuted after Derek (then aged 58 years) withdrew his statement. This is the only incident of violence recorded between the two men and took place 19 years before the tragic events of 24th December 2020. In 2001, there was no national risk assessment process for domestic abuse, nor were there concepts such as MARACs or regular information exchange between agencies. Nevertheless, positive action was taken by police and the alleged perpetrator was arrested. Again, at that time, there was not the current protocols in place with the Crown Prosecution Service regarding unsupported prosecutions in domestic abuse cases. The Victims Code of Practice (VCOP) was introduced by the Domestic Violence, Crime and Victims Act 2004 and came into effect from 2006. This was five years after this incident took place.

16.6.2 Derek visited his GP for routine appointments or annual check-ups. He attended the services of South Tyneside and Sunderland NHS Foundation Trust (STSFT) 12 times in the five years preceding his death (three times to the Emergency Department, twice to Sunderland Eye Infirmary and seven times as an outpatient).

16.6.3 Neither Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW – a mental health and disability Trust) nor the Probation Service had any contact with the victim.

16.6.4 Northumbria Police had early contact with the victim during the incident described in paragraph 16.6.1. They had extensive contact with the perpetrator over many years; predominantly due to his domestic abuse offending against several partners. On each occasion, positive action was taken when evidence was provided. Their actions were reviewed by the MASH (Multi Agency Safeguarding Hub). MASH staff check the accuracy of domestic abuse incident records. They also review the risk level and make necessary referrals to other support agencies when required. Their functions also involve a quality assurance role and to ensure all 'standard and medium' risk incidents are forwarded to Neighbourhood Police Team Inspectors. The 'high' risk domestic abuse incidents are then considered for further action such as inclusion in the MARAC meeting.

16.6.5 The North East Ambulance Service had only one contact with Derek (in 2016 for an unrelated matter) and on that occasion (when the ambulance had been called by his wife) he opted not to go with the crew and preferred to see his GP the next day.

16.6.6 Staff in all of the organisations involved in this review receive appropriate levels of training on identification and potential indicators of domestic abuse.

For example, STSFT staff have access to the Trust's intranet site where domestic abuse policies and guidance are located. From 2017, their front

line staff in the Emergency Department implemented a series of safeguarding questions to be asked of all patients:

- Able to access?
- Do you have any children or caring responsibilities?
- Any historical safeguarding concerns or alerts?
- Any safeguarding concerns with this attendance?
- Do you have concerns about your safety at home?
- Any actions to be taken?

Derek never raised any concerns to staff within STSFT on any of his 12 visits to hospital services over the five year period under review.

16.6.7 Probation Service staff receive mandatory training around domestic abuse. Their 'programme staff' undergo extensive additional training to be able to deliver an accredited programme such as the 'Building Better Relationships' programme.

16.6.8 North East Ambulance Service call-handling staff and frontline crews all receive safeguarding training, which does encompass domestic abuse and making safeguarding referrals.

16.6.9 At CNTW, all staff complete induction and level 1 safeguarding training which includes MARAC, domestic abuse definition and types of abuse. Clinical staff complete Level 2 which refreshes this.

16.6.10 Northumbria Police officers and key staff receive training in the 'Safe Lives' DASH risk assessment method, the National Decision-making Model as well as other multi-agency training linked to supporting victims and witnesses through the Victim's Code of Practice.

16.6.11 The perpetrator had contact with all agencies taking part in this review. In some cases the contact was extensive. His needs appear to have been addressed and will be considered in more detail elsewhere.

16.6.12 DHR panel discussions suggested that although in some organisations, the issue of 'adult family homicides' forms part of training programmes (for example a 'Think Family' approach), the identification of abuse between adults in the same household is not as widely understood as 'intimate partner' abuse. Staff are confident when assessing 'intimate partner' issues but there may be a gap when considering proactive risk management strategies within a wider household or wider family perspective.

16.7 **Did the agency have policies and procedures in place relating to domestic abuse? Were risk assessment and risk management processes for domestic abuse victims or perpetrators correctly used in this case?**

16.7.1 All agencies taking part in this DHR have either stand-alone domestic abuse policies in place or have safeguarding policies which contain a significant element of advice around domestic abuse.

16.7.2 In terms of risk management, the perpetrator's GP had notification given of Keith's involvement as a perpetrator which had been escalated to the MARAC (Multi Agency Risk Assessment Conference) stage. Primary Care staff have received training in understanding the risk assessment process within MARAC. However, MARAC outcomes are only sent to GPs if that GP practice has an action assigned to them. In summary, there is a good flow of information to GPs prior to a MARAC, but the outcomes of the MARAC are not automatically sent to the GP Practice. This is a gap in the information exchange.

16.7.3 STSFT's domestic abuse policy includes an appendix on 'enabling victim disclosures' and 'making safe' enquiries, plus two sets of guidance which were added in 2018 (during the review period for this DHR):

- *Identifying and responding to a patient disclosure of domestic abuse*

- *Employee domestic abuse guidelines*

STSFT also employs two dedicated professionals; a hospital based Independent Domestic Violence Advocate (IDVA) and a DAHA (Domestic Abuse Health Advocate). This is good practice. But in this particular case, there was never any suggestion of a disclosure from Derek.

16.7.4 Given the emergency response of ambulance crews and the requirement to assess and treat on scene, or assess and convey to hospital, frontline crews do not use the formal DASH risk assessment tool. Safeguarding training and the NEAS safeguarding policy does cover assessment of immediate risk and what to do under such circumstances. Options considered include a referral to police or Local Authority, use of a place of safety, or a handover to hospital staff with all relevant information to ensure ongoing safety planning.

NEAS staff also access the 'Think Family' training which considers who else within the property may be at risk.

16.7.5 After Keith's conviction for assault / harassment of his partner in 2019, the Probation Service placed risk register flags on their IT systems. These flags ensured practitioners could view and quickly identify known risks for that offender. The risk flags for Keith included his MARAC case (ex-partner high risk domestic abuse) and child concerns relating to access to his son.

16.7.6 Keith's risk assessment was completed within 15 days of his first appointment with the Community Rehabilitation Company (now renamed the Probation Service), which is compliant with their policy and guidance.

16.7.7 However, the probation officer's notes suggest they did not sufficiently explore the issues around domestic abuse. This includes looking more deeply into what the root causes might have been for Keith to act in an aggressive manner within domestic settings. The notes do record that Keith lives with his parents and that his parents disapprove of his alcohol use. Worthy of note in this case is reference made of Keith 'witnessing arguments between his parents due to his father's alcohol use'. But there was never any home visit carried out which would have been useful in verifying Keith's parent's views. To be fair, as the index offence was not committed against his parents, there is no expectancy of a home visit, but this does not mean one cannot take place. By visiting Keith at his home environment and liaising with his parents (i.e. fellow occupants of the address) it would have given a much more holistic view of the circumstances and perhaps influenced risk assessments and future planning. It should be acknowledged though, that probation officers carry a heavy workload, and this must be balanced against aspirational activities. There was never a disclosure to the Probation Service that Keith had ever behaved aggressively towards his parents. The opportunity for a home visit ended a few months later with the national lockdown of the COVID-19 pandemic.

16.7.8 The probation officer completed a 'risk of harm analysis section', including a Risk Management Plan and Sentence Plan. Within the plan, the details recorded of the index offence against his ex-partner are minimal. There is only limited analysis into the reasons behind Keith's behaviour.

16.7.9 Within the Risk of Serious Harm Summary, practitioners within the Probation Service are expected to detail:

- *Who* is at risk?
- What is the *nature* of the risk?
- *When* is risk most likely?
- What *circumstances are likely to increase* risk?
- What *factors are likely to reduce* the risk?

Probation officers then set a level of risk for the following groups:

- Children
- Public (including future partners)
- Known adults
- Staff
- Prisoners

The probation officer recorded 'intimate partners, any children in the relationship or who are in the household.' There is no information given about *when* these risks may occur. There is no mention of Keith's parents being at risk.

The level of risk assessed for children posed by Keith, was recorded as *medium risk of serious harm.* This appears to be below the correct level. The index offence included harassment towards his ex-partner. Part of that offending included following his partner while she was taking her children to school. The children witnessed their mother becoming upset and asking Keith to leave her alone. The information also states that her youngest child was with her in the supermarket when Keith had become threatening. A third piece of information highlights a domestic incident when Keith's ex-wife had to call the police due to his behaviour and that she was pregnant at the time. With all of this information available to the probation officer, it is reasonable to expect a safeguarding referral regarding the children to be made. This did not happen.

16.7.10 The Risk Management Plan (recorded on the Probation Service 'OASys' system), sets out what contact Keith will have, with whom, how often and what work is likely to be covered whilst on the order. It should also include all other agencies involved and the support in place. The plan was adequate in terms of containing general information on what was happening in Keith's case to manage risk. However, some aspects of the plan fell short; the details of the alcohol support services were not included, no explanation of *how* Keith's family were a source of support to him and that 'home visits will be by appointment' (without giving details about *when* home visits should occur).

. The mention of home visits is also confusing. As already stated, they were not expected in all cases and no such visits took place in this case. So why record notes that suggest they will be taking place?

16.7.11 When reading three elements within Keith's assessment, a common theme emerges:

1. Criminogenic needs are listed as relationships, lifestyle, alcohol use, thinking & behaviour and attitudes.

2. Risk factors are shown as relationships and alcohol.

3. Keith's own issues raised in his self-assessment questionnaire are 'drinking too much alcohol, losing my temper and understanding people's feelings'.

Keith's problems with his temper and particularly when alcohol is involved are clearly shown. This is reflected in the two objectives given to Keith:

(a) Increased awareness of offending behaviour
(b) Alcohol – increased abstinence

16.7.12 Alongside the recordings on the 'OASys' system, probation officers are also expected to complete a Spousal Assault Risk Assessment (SARA) which determines the level of risk to intimate partners and others. The SARA was completed but there are gaps. The risk is documented as 'low risk' to partners and 'medium risk' to others, namely his ex-wife and her adult daughter. But the SARA places these risks the other way around. As the probation officer completing the SARA no longer works for the Probation Service, this is not something that can be verified. It could be simply a clerical error or it could be that the probation officer did not complete an accurate, reflective risk assessment.

16.7.13 At all stages of the order, the probation officer had access to police information about Keith. When a person on probation is required to complete a BBR programme, there is a pro-forma sent to the police, asking for regular information to be shared. This information request was sent on 15th November 2019. In addition a link worker kept Keith's ex-partner updated on Keith's progress on the BBR programme. These two elements demonstrate excellent communication and should be considered good practice. However, the historic incident of violence between Derek and Keith was not shared by police. The context of this information sharing is that the incident was nearly 20 years earlier. It is accepted that the sharing of information must be balanced by relevance, recency and not be excessive. Nevertheless, in this particular case, clearly it created a gap in the picture available to the probation officer.

16.7.14 Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust (CNTW) is a mental health and disability trust and was involved in supporting Keith. CNTW has a domestic abuse policy for staff to follow. The policy clearly explains what actions need to be undertaken when domestic abuse is suspected or disclosed. The expectation is for practitioners to complete the 'Safe Lives' nationally recognised domestic abuse risk assessment.

16.7.15 CNTW also uses a 'Functional Analysis of Care Environments' (FACE) risk assessment tool. Part of the FACE risk profile requires staff to assess risk of violence / harm to self or others. In this case, the addictions worker was aware of Keith's BBR requirements.

16.7.16 Northumbria Police use the DASH risk assessment method when dealing with all domestic abuse incidents. They have a comprehensive policy on 'protecting vulnerable people,' linked to 'APP' (Authorised Professional Practice) which sets out domestic abuse procedures to be followed by front line staff, and subsequent reviews or partnership approaches, to protect victims and reduce offending.

16.8 Did the agency comply with domestic violence and abuse protocols agreed with other agencies including any information sharing protocols?

16.8.1 There is evidence of good and effective information exchange taking place in Keith's case. For example, the exchange already highlighted between the Probation Service and Northumbria Police.

16.8.2 Information was also shared in Keith's MARAC case with his partner in 2019, including with his GP, CNTW, STSFT and Northumbria Police. However, there was no 'flag' from the MARAC case on the NEAS systems. The flags usually relate to addresses but they do also include individual details. This is a gap in information available to front line crews

16.8.3 CNTW and STSFT ensured that Keith's health record was updated with an alert about his domestic abuse offending which would let practitioners know about his circumstances. However, there are also gaps in such information exchange between the Probation Service and health professionals (e.g. GP, acute hospital trust or the mental health trust). In summary, professionals from different organisations who were supporting Keith did not know of the other agency's involvement, even though this was sometimes on the same or next day.

16.9 What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

16.9.1 The GP Practice had no opportunities with the victim as there was never any suggestion by Derek of a risk from his son. Derek and Keith were registered at separate GP Practices.

16.9.2 For the perpetrator's GP, there were opportunities to explore his mental health symptoms and the challenges he was facing. There was an also opportunity to explore his alcohol excess and the effect on his behaviours. Primary Care was offering him access, support and a listening ear. He was appropriately referred to community based services to address both his mental health and substance misuse issues. There was also appropriate prescribing of medication. However, there was no recorded use of a depression scaling questionnaire or an alcohol screening tool. These tools, such as 'PHQ9' and 'Audit C' are evidence based tools that should be used in screening and scaling in Primary Care where appropriate.

16.9.3 With STSFT, the decision-making was predominantly around the victim's or perpetrator's medical care. But STSFT did ask the standard 'safeguarding questions' to both Derek and Keith. Both patients were seen alone, which is good practice. No disclosures of abuse were made.

16.9.4 NEAS had no information held regarding any domestic abuse between the victim or perpetrator.

16.9.5 Keith was managed for a lengthy period by the Probation Service following his conviction for a domestic abuse related matter (assault and harassment of his ex-partner). There was no home visit carried out during his period of supervision. Although it is not mandated to do so, such a visit by the Probation Service would have added value. Keith's probation officer never met his parents. The Probation Service were aware of Keith's previous assaults on his intimate partners but it appears that police did not inform them about the assault on his father many years earlier.

16.9.6 CNTW carried out a robust assessment in relation to Keith's alcohol dependence and his desire to be abstinent. The assessments and treatment plans were made based upon the self-reporting by Keith (CNTW were never formally informed by the Probation Service of the existence of the community order). Nor were they informed of his arrest for a drink-driving offence. Similarly they did not appear to seek consent from Keith to discuss his treatment with probation staff.

(MARAC and MATAC)

16.9.7 The 'MARAC' is a multi-agency forum, chaired by a senior officer from Northumbria Police. An action from the MARAC in November 2019 was to forward the perpetrator's details (Keith) to the 'MATAC' as he was assessed as a serial perpetrator of domestic abuse. MARAC make plans to protect the victims of high risk domestic abuse cases. MATAC focusses on managing a serial perpetrator of domestic abuse.

16.9.8 This referral from MARAC was considered by the MATAC manager the following day but rejected. MARAC is a victim led approach and develops plans to protect the highest risk victims of domestic abuse. A MATAC referral would concentrate on the offender. Reasons for the nomination to, and subsequent rejection by, the MATAC will be explored in a separate term of reference but clearly if Keith had been considered as a MATAC subject, there would have been an opportunity for professionals to meet and discuss all issues relating to him including relationships, violence, potential victims and his misuse of alcohol.

16.10 **Were there any opportunities for professionals to raise safeguarding concerns in relation to the perpetrator's parents?**

16.10.1 The GP Practice had no such opportunities as Derek did not disclose or suggest any problems at home with his son. This was mirrored during his attendance at Sunderland Hospital and Sunderland Eye Infirmary. Derek did not suggest any problems and when asked the hospital's safeguarding questions, gave a negative response.

16.10.2 The Probation Service did have an in depth knowledge of Keith's issues but never met his parents. No concerns are raised in the professionals' notes during their meetings with Keith, as he was not assessed as a risk to them.

16.10.3 The incident when Keith attacked his father took place in 2001. However, the information was still available on police systems. This information was not shared with other professionals at the MARAC meeting in 2019. Although historic, this information was highly relevant both to the MARAC and to his probation officer who was to manage Keith's community order. Keith was known for violence to many other victims, known to regularly abuse alcohol and was known to police for a previous assault on his father. He was now living back with his parents. This was a missed opportunity for the police to share the vital information about that historic incident.

16.10.4 NEAS had no information passed to them, nor did any ambulance crew observe anything that gave an indication Keith was a danger to his parents, prior to the incident in December 2020.

16.10.5 CNTW were aware of Keith's previous domestic abuse offending with previous partners as there was an alert on their systems relating to the assault on his partner in November 2019. They also knew he was on a 'Building Better Relationships' programme as part of his community order. Keith's mother rang CNTW's 'Initial Response Service' (IRS) stating that he had been making threats when intoxicated. This was a clear and unambiguous disclosure. Keith was living with his parents. They were therefore at risk. His behaviour was threatening and alcohol was highlighted as the reason. No risk assessment relating to Keith's parents was carried out by IRS staff nor did they inform Keith's probation officer. This meant no follow-up action took place. The IRS worker did contact Keith's GP but this has to be regarded as a missed opportunity to intervene and raise safeguarding concerns in relation to the perpetrator's parents.

16.11 When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?

16.11.1 Within Primary Care, Derek was accessing his GP appointments as and when there was a health need. He had regular appointments which were arranged proactively by the GP Practice. He was regularly offered health promotion and 'better health' messages.

16.11.2 The victim's attendance at STSFT facilities were to address his medical needs. He was never in the company of his son and there was never any suggestion he felt at risk.

16.11.3 NEAS only received one call (in 2016), prior to the call on 24th December 2020 relating to Derek. It was Derek's wife who had rung. There was no mention of domestic abuse and no mention of the son being present at the time.

16.11.4 Neither CNTW nor the Probation Service had any contact with the victim.

16.11.5 Northumbria Police did not have any further direct dealings with Derek after the incident in 2001.

16.12 **What information was known about the perpetrator? How accessible were services?**

16.12.1 In terms of Primary Care, the perpetrator had a different GP Practice to his father. Keith's GP was aware of much of the information held about Keith's behaviour. The Practice did receive notification of a MARAC (high risk domestic abuse) case with Keith's partner as the victim. This included an earlier restraining order (in 2014) and previous evidence of stalking behaviour. However, with existing protocols, the GP was not updated on the outcomes following the MARAC (as there was no action assigned to the GP Practice). They were not informed that Keith was the subject of a court mandated Building Better Relationships programme as part of his community order (all of this information was shared at the MARAC).

16.12.2 The perpetrator had six attendances at the Emergency Department at Sunderland Royal Hospital (24/7 emergency service). In 2013 he stated he was unwell and had been suffering a lot of stress. He told staff he was going through a divorce. Practitioners documented he was agitated and anxious and he disclosed he was drinking excessively (one bottle of wine per night). He was discharged home with a plan to be followed up by his GP. During another attendance in 2017 he disclosed he had taken cocaine

on a night out. Again, there was a follow-up letter to the GP to access other services. In March 2020 during an attendance at the Emergency Department he was accompanied by police as he was in custody. He had sustained a head injury and told staff he wanted them to help him to kill himself. Under those circumstances, normal practice would have been to involve the Psychiatric Liaison Team, but Keith had left prior to an assessment. Further information was gathered during his next attendance (in May 2020). He was feeling unwell and 'off his head' since commencing taking his medication. He was advised to stop the medication and a discharge letter was sent to his GP.

16.12.3 The North-East Ambulance Service were called twice about the perpetrator in 2017. The first call was from his mother and related to shortness of breath. Keith disclosed he had taken cocaine. He was taken to hospital where he accessed other services. The second call was from Keith himself. He reported a history of anxiety attacks. He was coached with his breathing during the journey in the ambulance. He was taken to hospital for further treatment and additional care.

16.12.4 There was another call to NEAS in 2020 (again by his mother) when Keith was threatening self-harm. The call-taker spoke directly with him. He denied he was suicidal. He did not want an ambulance. The call-taker then spoke again with his mother and advice was given.

16.12.5 Northumbria Police held a lot of information about Keith. They had details recorded of his alcohol dependency including an entry by a health care professional from his time in police custody in November 2019 which stated '*continues to deny alcohol dependency, has been assessed by HCP and has finally admitted to having issues. Be aware regarding any future instance and likelihood of withdrawal.'* Police also had information held regarding Keith's previous 19 arrests and 7 convictions for harassment, threatening behaviour, battery, assault, driving with excess alcohol and affray. In addition, Northumbria Police had recorded 17 previous domestic abuse incidents where Keith had perpetrated violence or abuse towards his father and three previous partners.

16.12.6 The Probation Service had extensive contact with the perpetrator. This is explored in other areas of the terms of reference.

16.12.7 CNTW were aware of the perpetrator's previous MARAC involvement. The Addictions Service were unaware of the victim's details as there was no contact made with Keith's probation officer. The Addictions Service was accessible to the perpetrator. Indeed, when he (repeatedly) missed appointments, there were regular follow-ups to offer further assistance with his alcohol abstinence.

16.13 **Was the perpetrator subject to MAPPA, MATAC or any other perpetrator intervention programme? Were there any injunctions or protection orders in place?**

MAPPA is the Multi-Agency Public Protection Arrangements. These are statutory processes to manage sexual and violent offenders. The 'Responsible Authorities' (police, National Probation Service and HM Prison Service) all have statutory responsibilities to protect the public under national MAPPA guidelines).

MATAC is Multi-Agency Tasking and Coordination. It is a scheme currently being rolled out in many areas across the UK to specifically manage serial and repeat perpetrators of domestic abuse

16.13.1 The perpetrator was never a MAPPA subject as his offending and sentencing did not meet the very high bar for inclusion in MAPPA as a violent offender. He has become a MAPPA subject since killing his father.

16.13.2 He had been a MARAC (highest risk domestic abuse cases) subject (perpetrator with his ex-partner). The case was listed at MARAC on 13th November 2019. The comments at the meeting describe Keith as a '*serial DV offender'* (domestic violence). Therefore the action from the meeting was to nominate Keith as a 'MATAC' subject. This would facilitate additional work to manage his behaviour. However, checks carried out since the domestic homicide show that Keith was never heard at the MATAC.

16.13.3 Further scrutiny carried out during this DHR process shows that the MARAC meeting took place on 13th November 2019. The referral from the MARAC was considered by the MATAC manager the following day but rejected. The reason recorded is that it '*did not meet the criteria of a serial perpetrator'.* We know that Keith had assaulted four victims as a perpetrator of domestic abuse. These included his father and three former intimate partners. The MATAC uses a scoring system to establish the level of risk. The process uses an analytical method called 'RFGV' (Recency, Frequency, Gravity and Victims).

16.13.4 Keith's score on the matrix had fluctuated over the years. At one point it was as low as 6. This increased in 2016 to 22 and to 31 in 2019 before decreasing in 2020. The matrix is scored out of 100. To give some context to this, Keith's 'score' can be compared to other serial perpetrators; in Sunderland at the time of Keith's referral there were 1584 other perpetrators that had a higher score than him (and therefore assessed at potential greater risk of committing harm).

16.13.5 Northumbria Police Force policy is to prioritise those serial perpetrators that may cause the most harm. The caseload 'live' within MATAC at any one time is around 10 – 12 cases. To increase the number of perpetrators within the process would simply dilute the effectiveness of the proactive management of these perpetrators. In particular, the Force policy defines a serial perpetrator (in terms of a MATAC nominal) as 'more than one domestic abuse incident in the last two years against more than one victim.' With the time gap in Keith's abuse towards ex-partners, he did not meet this criteria.

16.13.6 Keith was clearly a 'serial perpetrator'. However, risk assessments and policy meant he was not included in the MATAC process. Because he was under the threshold for inclusion within the MATAC programme, he should have been managed by a Neighbourhood Police Team. It is unclear if or how this took place. Neighbourhood Police Teams have a variety of duties within their localities. More focus and planning is required if they are to effectively manage the risks around a perpetrator.

16.13.7 The GP Practice was aware Keith had previously been listed at MARAC but were not aware of his community order and associated 'Building Better Relationships' programme.

16.13.8 No information about his community order was known to South Tyneside and Sunderland NHS Foundation Trust. NEAS also had no such knowledge.

16.13.9 CNTW were aware of the BBR programme (there is reference to it in their practitioner's notes) but this was only due to self-reporting by Keith. There was never a discussion about the details of the community order with the Probation Service.

16.13.10 Keith was sentenced at court on 6th November 2019 for assault and harassment against his ex-partner. He received an 18 month Community Order. The Northumbria Community Rehabilitation Company (CRC) were allocated the case (since reorganisation the restructuring has meant they are now back as part of the Probation Service). The CRC worked with Keith on 15 days' Rehabilitation Activity Requirement (RAR) and a Building Better Relationships (BBR) programme.

16.13.11 The BBR programme is designed to address issues around domestic abuse, within a group setting. Keith was still subject to these requirements when he killed his father.

16.13.12 Several years earlier, (in 2013), Keith had been sentenced to an 18 month 'Suspended Sentence Order' for assaults upon his ex-wife and her adult daughter. This was a different victim to the one he assaulted and received a second court sanction in 2019. At that time, he completed the BBR programme and so had knowledge of the programme content. The risk assessments from 2013 showed a pattern of abusive behaviour towards his partners. This included several police call-outs.

16.13.13 It is not unusual that a person would be instructed to complete an accredited programme more than once. In this case, it appears that Keith completed the BBR element on 26th September 2014 and records indicate that he engaged well and met the required learning objectives. When completion of the BBR programme was recommended again in the pre-sentence report dated 6th November 2019 following Keith's assault against another partner, a significant period of time had elapsed since he completed the same programme in 2013. As this was a further domestic related assault, this was an appropriate recommendation and disposal. It is difficult to state with any accuracy any single cause for recidivism in this case. Of course, there may have been an element of disguised compliance during the first programme. Or it could be that Keith failed to practice or apply the strategies he had learned during the programme, or even that he chose to disregard any learning gained from the programme. At regional level, the Probation Service do not track and record recidivism rates for perpetrators who have completed an accredited programme such as BBR.

16.13.14 Keith did miss several of his appointments with both his probation officer and with the programme staff who were delivering the BBR programme.

16.14 **Were senior managers of the agencies and professionals involved at the appropriate points?**

16.14.1 There is evidence throughout the review of regular involvement of managers and oversight where necessary. There were 'triggers' during the perpetrator's BBR programme (e.g. his arrest for drink-driving) but these did not require specific escalation under Probation Service guidelines and working practices.

16.14.2 There is a lot of evidence demonstrating oversight within a MASH setting (Multi Agency Safeguarding Hub). This includes reviews of risk assessment levels and follow-up actions.

16.15 **Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?**

16.15.1 There were no language, religious or cultural barriers that affected the victim or perpetrator. The victim was not registered with any disability.

16.15.2 Although the perpetrator suffered with alcohol dependency, this was not registered as a disability. Keith was referred to specialist addiction services to support him with his alcohol and drug use.

16.16 **Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?**

16.16.1 There have been eight other Domestic Homicide Reviews carried out in Sunderland since the process became mandatory in 2011.

16.16.2 Two of these previous DHRs involved a 'wider family homicide'. The remainder were 'intimate partner' homicides or suicides. One previous DHR in Sunderland involved a male victim.

16.17 **Did any restructuring during the period under review have any impact? How did the onset of the COVID-19 pandemic affect service delivery?**

16.17.1 There was no restructuring in the North-East Ambulance Service nor Northumbria Police during the time frames for this review. Neither was affected by the COVID-19 pandemic as they are 24/7 emergency responders. Face to face contact was maintained.

16.17.2 In 2016, two separate health trusts created a formal strategic alliance. In April 2019, the South Tyneside and Sunderland NHS Foundation Trust was formed. This did not have any impact on services. In terms of COVID-19, the Emergency Department continued its 24/7 availability. However, in line with most medical support services nationally, there were cancelled

appointments and far reduced face to face contact from many trust services.

16.17.3 The GP Practice also moved its services to telephone based during the pandemic.

16.17.4 The COVID-19 pandemic significantly affected the services of the Probation Service. Keith had only started his BBR programme in March 2020. He had begun attending group sessions. When a subject is starting the 'treatment' element of an order, it is important that this continues. Unfortunately, with a national lockdown, local professionals adhered to the new national guidance for services to move to an 'Exceptional Delivery Model'. Contact was limited to telephone communication. The accredited programmes were halted. Keith did have regular telephone contact with a programme facilitator but this fell way below the input of the core work that had started on the BBR. The telephone sessions were more akin to 'catch-up' chats, rather than continuing to explore issues around thoughts, feelings and behaviours. Similarly, Keith did not see his own probation officer face to face for many months. This may have impacted on his compliance levels. Although there had not been any home visits (and so the probation officer did not meet the victim or his wife), we cannot know, during the progression of the order, if these may have become an option for the probation officer to consider. Again, no such visits were possible within the national lockdown regulations.

It is also of note a national programme to transition Community Rehabilitation Companies and the National Probation Service into a single unified Probation Service began during 2019 and was not completed until 26th June 2021. This had an impact upon staff retention, use of agency staff, workloads and morale over that period.

16.17.5 With the onset of the pandemic, the perpetrator was also unable to have face to face support from the Addictions Service at CNTW. He did continue with the offer of telephone appointments but his response became sporadic.

Section 17: Conclusions and Lessons Learned

17.1 This is a tragic case of an adult male killing his own father during a violent, drunken attack.

17.2 The perpetrator was known to many services as a violent man who had previously assaulted his partners and his father as part of his domestic abuse.

17.3 Alcohol (and to a lesser degree drug abuse) was a significant part of the perpetrator's life. We know of an incident of violence in 2001 when both Derek and Keith received injuries. Both were said to be drunk at the time. Keith also disclosed that he lost a friend who died through alcohol abuse. He was not diagnosed as alcohol dependent, but alcohol was clearly a trigger for his violent behaviour to others and also for his own thoughts of self-harm. He was offered referrals to other specialist services but frequently missed appointments or did not return calls to professionals.

17.4 The service supporting him in his excessive alcohol misuse carried out an excellent comprehensive assessment of the perpetrator's needs but there was no consideration of the risks he posed to others, such as partners or wider family members sharing a home with him.

17.5 There was poor communication between agencies regarding the perpetrator's Community Order and the associated 'Building Better Relationships' (BBR) programme. There is no recorded contact between the probation practitioner and 'Wear Recovery' (CNTW's addiction service). Keith was not made subject to a statutory requirement by the Court such as an Alcohol Treatment Order. If he had been, then this would have provided the authority for information sharing. As Keith's involvement with 'Wear Recovery' was voluntary, any information sharing between the two agencies would have required Keith's written consent. However, whilst the Probation Service would not routinely notify addiction services of their involvement with an individual, it would be considered good practice for the probation practitioner to seek the consent of the person on probation to speak with caseworkers from Wear Recovery and to share relevant information for those cases in treatment.

17.6 He was referred to the MARAC in Sunderland (the Multi-Agency Risk Assessment Conference) in 2019 in relation to an assault and harassment of his ex-partner. The MARAC meets to discuss the highest risk cases (where the victim is at risk of serious harm). An action from that meeting (in November 2019) was to refer the perpetrator to the MATAC process. The MATAC considers actions to prevent further domestic abuse by serial perpetrators. Keith was correctly identified as a serial perpetrator of domestic abuse. But the action of forwarding his case from the MARAC to the MATAC did not take place. This was a missed opportunity to carry out a

focussed intervention with Keith. He was about to start the BBR programme. But a MATAC referral would have ensured all agencies were aware of the case and potentially offer a more holistic approach. Without it, agencies were acting in isolation. It is accepted that cases must be prioritised if the highest risk offenders are to be effectively managed under the MATAC process. But once rejected by the MATAC threshold, there does not appear to have been any update provided to the MARAC Chair. As the perpetrator's nomination as a MATAC subject was the only action from the MARAC meeting, this meant a lack of ownership.

17.7 Action was not always taken when the perpetrator failed to comply with elements of his community order. This was a mandatory sanction after his conviction at court. It was managed by the Probation Service. Of 68 appointments offered to the perpetrator, 37 of these were kept. Nine of the absences were recorded as 'acceptable' (due to medical reasons, court or rescheduled by the probation practitioner).Two were recorded as 'unacceptable.' The other twenty absences are not recorded and appear to be technical errors on the probation system as a result of the automatic scheduling in advance of appointments, in relation to expected attendance at groups. Many of these errors were due to COVID-19, the imposition of an Exceptional Delivery Model and incorrectly showed as a 'failed' appointment. So in summary, Keith's attendance was satisfactory but there was no challenge to his two unacceptable absences.

17.8 Clear evidence of escalation and tension was given in May 2020 when the perpetrator's mother telephoned the Initial Response Service at the Cumbria, Northumberland and Tyne & Wear Mental Health Trust. She described her son as an alcoholic who had been drinking since the breakdown of his relationship and that he was going to 'kill someone'. Although there was a 'FACE' risk assessment completed by 'Wear Recovery' in June 2020, the assessed level was 'low apparent risk'. This assessment did not reflect the information from the previous month recorded by the Initial Response Service following the telephone call from his mother, though it did include a 'risk of harm to others'. However, this information was not shared with other agencies.

17.9 The victim lived at home with his wife. Their son had been staying at their home intermittently for several years. They were a source of support to him. The victim had been assaulted by his son, 19 years before the attack that led to his death. There are no further records of any threats or assaults on his father. Since 2001, Derek did not disclose or even suggest to any professional that he felt at risk of harm from his son.

17.10 The COVID-19 pandemic and the associated national 'lock-down' had a significant impact on this case. Many services had to adapt their delivery models as staff were prevented from meeting their clients face to face. Telephone contact replaced meetings in person. This affected GPs, the CNTW services and the Probation Service. Although the perpetrator was

still active to the Probation Service, these new restrictions meant that the offender had to withdraw from group work, had no personal face to face contact with his probation officer or his programme team staff member and was left to his own devices at home (when his work had been identified as a supportive factor). It also meant that if tensions were suspected, there was no chance of a home visit which could have collated more information through direct conversations with the perpetrator's parents. The unified Probation Service now has a 'Home Visit Policy Framework' in place alongside a set of National Standards for Practice. Consideration must be given in each case to a home visit. Those considered high risk must have one completed within a set timescale. If a home visit is not considered necessary, a clear rationale as to why that is the case must be recorded.

Section 18: Recommendations

1) Agencies should explore the feasibility of closer liaison between the Probation Service, Cumbria, Northumberland and Tyne & Wear NHS Trust, the GP Practice and other support services when a perpetrator is being managed as part of a mandatory order imposed by the courts. Even in cases where there is no Alcohol Treatment Order in place, such dialogue (subject to data protection considerations and existing Information Sharing Agreements) would be a valuable tool in managing risk.

2) The Probation Service, Mental Health Trusts and commissioned substance misuse services should review their policies regarding involvement with family members of clients, patients and offenders. A risk assessment can only be enhanced if there is a full picture of the home environment. Including other members of the household will provide better protection for the wider family.

3) Sunderland Partnership should review the processes for managing serial or repeat perpetrators of domestic abuse. The existing MATAC structures have only limited resources. These should remain in place in order to manage the highest risk cases. However, there are gaps in the level of proactivity in managing those serial domestic abuse perpetrators that fall outside the MATAC process. Multi-agency policies should be updated to incorporate a review of review of resources, briefings and toolkits that can be made available to those professionals managing these individuals.

4) The distribution of actions and minutes following a MARAC meeting should be reviewed. Some agencies (notably GP Practices) receive all relevant information prior to the meeting but do not receive a full account of the actions, deliberations and updated information emanating from a MARAC discussion, unless there is a specific action for that particular GP Practice. Improved information sharing of these MARAC outcomes would assist such services when considering the safety and welfare of their patients.

5) Sunderland Partnership coordinates a training event, utilising this DHR, to support the awareness of the issue of ‘adult family homicide’. There have been significant improvements in the identification of domestic abuse in recent years; particularly around such elements as physical, sexual and economic abuse and coercive control within intimate partner relationships. Some agencies remain confident that staff are also aware of the issue of wider household violence. However, more multi-agency awareness raising should take place relating to the significant violence and abuse taking place across the wider family environment and in particular how professionals can manage these risks.

6) Sunderland Partnership (supported by the Safeguarding Adults Board and Children's Partnership) should ensure there are clear and accessible pathways for victims of wider familial abuse to seek help and support.

References:

Multi-agency statutory guidance for the conduct of domestic homicide reviews (Home office 2016)

Domestic Homicide Reviews 'Key findings from analysis of domestic homicide reviews' (Home Office 2016)

'The Social Worker's Guide to The Care Act 2014.' (Pete Feldon 2017)

'A Practical Guide to the Mental Capacity Act 2005.' (Matthew Graham and Jakki Cowley 2015).

'Working together to safeguard children' (HM Government 2015, revised 2018)

MAPPA guidance (Ministry of Justice 2012)

PEEL Inspections into domestic abuse (HMICFRS November 2017)

Vulnerability, Knowledge and Practice Programme (Home Office, National Police Chief's Council, College of Policing 2020-2021)