THE SAFER ROTHERHAM PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

Victim MA 1

November 2014

CONTENTS

1. INTRODUCTION

1.1 The principal people referred to in this report are:

MA 1	Victim	White British
MA 2	Perpetrator	White British

1.2 In autumn 2013 MA 1 died in hospital from hypoxic anaemic brain damage caused by hypovolaemic shock with cardiac arrest resulting from an incised wound to his right hand caused by a broken bottle. South Yorkshire Police [SYP] charged MA 2 with the murder of MA 1.

1.3 In spring 2014 MA 2 pleaded guilty to manslaughter. He was sentenced in summer 2014 to five and a half years imprisonment.

2. ESTABLISHING THE DOMESTIC HOMICIDE REVIEW [DHR]

2.1 Decision Making

2.1.1 The Safer Rotherham Partnership [SRP] chair established a DHR. There was a significant volume of information and the chair decided that the DHR would be completed by December 2014. The Home Office was informed.

2.2 DHR Panel

2.2.1 David Hunter was appointed as the Independent Chair and Author. He is an independent practitioner and has never been employed by any of the agencies involved with this DHR.

The Panel comprised of:

- Ruth Fletcher-Brown — Rotherham Metropolitan Borough Council [RMBC] Public Health
- Annette Carey — Choices and Options [C&O] Area Manager
- Alison Lancaster — Rotherham Doncaster and South Humber NHS Foundation Trust [RDaSH] Mental Health
- Sue Ludham — South Yorkshire Probation Trust [SYPT] Deputy Director
- Helen Greig — Action Housing and Support Director of Client Support Services
- Helen Wood — Safeguarding Adults Coordinator and Domestic Abuse and Independent Domestic

	Violence Advocacy [IDVA] Manager, RMBC Adult Services
➢ Jason Horsley	Consultant Public Health RMBC
➢ Elisa Pack	Victim Support Senior services Delivery Manager
➢ Cherryl Henry-Leach	SRP Domestic Abuse Coordinator RMBC
➢ Sam Newton	Service Manager Safeguarding Adults RMBC
➢ Steve Parry	SRP Neighbourhood Crime and Anti-Social Behaviour Manager RMBC
➢ Katie Sidebottom	Key Worker Care and Supported Housing
➢ Helen Smith	Sergeant SYP
➢ Rob Stanton	Headway
➢ Jean Summerfield	Rotherham NHS Foundation Trust Named Nurse Adult Safeguarding
➢ Victoria Swinbourne	Lifeline Service Manager
➢ Sue Bower	Safeguarding Adults Lead Professional Rotherham Doncaster & South Humber NHS Foundation Trust [RDaSH]
➢ Matt Pollard	Drug and Alcohol Services Manager RDaSH
➢ Alun Windle	Rotherham Clinical Commissioning Group post
➢ Paul Walsh	Housing and Communities Manager RMBC
➢ David Blain	Head of Safeguarding Yorkshire Ambulance Service
➢ Sue Wynne	Refuge Coordination Rotherham Woman's Refuge

2.3 Agencies Submitting Individual Management Reviews [IMRs]

2.3.1 The following agencies submitted IMRs.

- Choices and Options
- South Yorkshire Police
- Housing and Neighbourhood Services RMBC
- Headway
- Action Housing and Support

- Rotherham NHS Foundation Trust
- South Yorkshire Probation Trust [as was]
- St Ann's Medical Centre
- Stag Medical Practice
- Lifeline
- Adult Services RMBC
- Yorkshire Ambulance Service
- Sheffield Teaching Hospitals NHS Foundation Trust
- RDASH [mental health and substance misuse]
- IDVA

Non IMR written information was received from:

- Metropolitan Police Croydon
- Victim Support

2.4 Notification/Involvement of Families

2.4.1 The families of MA 1 and MA 2 were briefed by SYP Family Liaison Officers and provided with copies of the Home Office leaflet on domestic homicide reviews.

2.4.2 The SRP Domestic Abuse Coordinator and the DHR independent chair/author met with MA 1's sister in May 2014. Her views appear in the report as appropriate.

2.4.3 MA 2's mother was last written to in June 2014 inviting her to contribute to the DHR. She did not reply and the DHR Panel felt it was inappropriate to contact her again.

2.4.4 MA 2 did not respond to two letters inviting him to contribute to the review.

2.5 Terms of Reference

2.5.1 The purpose of a DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result
- Apply these lessons to service responses including changes to policies and procedures as appropriate

- Prevent domestic violence, abuse and homicides and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working

  [Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2013] Section 2 Paragraph 7]

2.5.2 Timeframe under Review

The DHR covers the period spring 2007 [the time around which MA 2 sustained a brain injury, to MA 1's death in autumn 2013. Contextual information predating 2007 is also included.

2.5.3 Case Specific Terms

1. Were the risk indicators for domestic abuse present in this case recognised, properly assessed and responded to in providing services to MA 1 [the victim] and MA 2 the alleged perpetrator? If not, what was the reason for this?

2. Were the services provided for MA 1 and MA 2 timely, proportionate and "fit for purpose" in relation to the levels of risk and need that were identified?

3. How did agencies ascertain the wishes and feelings of MA 1 and MA 2 about their victimisation/position and were their views taken into account when providing services or support?

4. How effective was inter-agency information sharing and cooperation in response to MA 1 and MA 2's situation? What consideration was given to sharing information between agencies from different authorities in support of MA 1 and MA 2 and was it effective?

5. How do agencies within the Safer Rotherham Partnership support victims from LGBT [lesbian, gay, bisexual and transgender] and other minority groups who disclose domestic abuse?

6. How were any racial, cultural, linguistic, faith or other diversity issues, taken into account during assessments and provision of services to MA 1 and MA 2?

7. Were the reasons for MA 2's abusive behaviour properly understood and addressed? Was there sufficient focus on reducing the impact of MA 2's abusive behaviours towards MA 1 by applying an appropriate mix of sanctions [arrest/charge] and treatment interventions?

8. Were single and multi-agency policies and procedures, including the MARAC protocols, followed and are they embedded in practice and were any gaps identified?

9. How effective was the supervision and management of practitioners involved with responding to the needs of MA 1 and MA 2's. Did managers have effective oversight and control of the case?

10. Were there any issues in relation to capacity or resources within the Partnership and its agencies that affected the ability to provide services to MA 1 and MA 2 or to work with other agencies?

On 06.02.2014, at the second Panel meeting, it was agreed that the terms of reference would be revised to include the following points for consideration by IMR authors:

11. Was the risk to family members of MA 1 and MA 2, in particular their mothers, recognised as Domestic Abuse?

12. When risks to family members were identified and managed, was the risk to either MA 1 or MA 2 as immediate partners considered?

3. History of MA 1 and MA 2

3.1 MA 1 and MA 2 were born and brought up in Yorkshire. MA 1 gained employment in care homes, a bakery and worked for a charity. MA 2 obtained jobs in local industry and qualified as a bus driver.

3.2 MA 1 and MA 2 formed their relationship in 1977 and generally lived together from the beginning. In 1986 MA 1 was sentenced to two years imprisonment at Croydon Crown Court for inflicting grievous bodily harm on MA 2 by stabbing him in the chest.

4 Presenting Issues pre 2007

4.1 The following were the presenting issues for MA 1 and MA 2.

MA 1	**MA 2**
Drug abuse	Several drug and alcohol overdoses
Anxiety	Heavy binge drinker
Depression	Will not accept mental health support
Unexplained Injuries	Unexplained injuries
Panic attacks	Drinking bottle of vodka daily
Referred to mental health	Relationship difficulties

Debt issues	Damaged skin removed from eye lid with scissors by MA 2; required corrective surgery

4.2 In 2007 the above problems still existed. MA 1 and MA 2 were in receipt of incapacity allowance and disability living allowance which continued until the homicide.

5. Brain Injury

5.1 In the spring of 2007 MA 2 suffered a bleed in his brain which required surgery. There is evidence that post his operation MA 2 became more aggressive. MA 2 received significant support to assist him with daily living and at one point MA 1 was his carer.

5.2 MA 1's sister knew from MA 1 that the relationship was abusive; primarily when they were in drink. She described the abuse as mutual with both men taking an equal part as the aggressor. She said this balance altered after MA 2's head injury when in her opinion MA 2 became the main instigator of abuse. She believed his head injury altered his behaviour as evidenced by MA 2's frustration at not being able to find the right words to use.

5.3 A formal assessment by adult services found: "MA 2 has cognitive issues due to damage to the frontal lobe of his brain. The subsequent brain injury caused substantial impairment to his cognitive functioning, memory and difficulties with processing information and sequencing tasks. When MA 2 experienced new situations he reported feelings of anxiety, depression and panic. MA 2 also noted acute mood swings which meant that he could exhibit both verbal and physical aggression. MA 2 acknowledged his misuse of alcohol magnified these issues".

6. PRESENTING ISSUES IN PERIOD 2007 TO HOMICIDE

MA 1	MA 2
Significant alcohol misuse	significant alcohol misuse
Significant domestic abuse	significant domestic abuse
Victim and perpetrator	victim and perpetrator
Mental health needs	mental health needs
{Suspected of finally exploiting}	{Financially exploited by a member of}
{his mother and MA 2}	{MA 1's family and possibly by MA 1}
Poor living conditions	poor living conditions
Causing trouble for neighbours	causing trouble for neighbours
Harassing his mother	severe physical health needs
Suicidal thoughts	suicidal thoughts
Alcohol induced seizures	self-harm
Physically stringer than MA 2	stabbed in arm

7. Commentary on MA 1 and MA 2

7.1 MA 1 and MA 2 were in a long-term abusive relationship. The first recorded incident was in 1985 when MA 1 stabbed MA 2. The incident was serious as reflected by the two-year prison sentence MA 1 received in early 1986. It is probably fair to say that MA 2 made a complaint and supported the prosecution; the actions of a person who was not prepared to tolerate domestic abuse.

7.2 In the time between then and the start of the DHR period [01.04.2007] there is evidence within the combined chronology that MA 1 and MA 2 had periods of depression, abused alcohol and that MA 2 was the victim of domestic abuse perpetrated by MA 1. Therefore by 01.04.2007 a significant number of corrosive factors were present in their relationship. Added to this was the head injury suffered by MA 2 when he fell in February 2007.

7.3 Agencies were involved in assessing and supporting MA 1 and MA 2 for a variety of medical and non-medical needs. Following MA 2's head injury, MA 1 was noted as his carer and at times was also a carer for his own mother. There is some suspicion, fuelled by MA 2 that MA 1 was financially exploiting his mother and MA 2. Adult services took effective action and stopped the exploitation of his mother. MA 1's mother was recognised by some agencies as being vulnerable and she also witnessed abusive between her son and MA 2. The pair were verbally abusive towards her but she always supported MA 1 and decline to initiate any action against him.

7.4 One agency acknowledged that it had not recognised domestic abuse between MA 1 and MA 2's because it was taking place within a same sex relationship.

7.5 South Yorkshire Police had extensive involvement with MA 1 and MA 2. Officers attended over 50 incidents between the couple. MA 1 was arrested three times for assaulting MA 2, and MA 2 was arrested twice for assaulting MA 1. Despite the imposition of sanctions the domestic abuse continued.

7.6 The pattern of abuse altered from MA 1 being the aggressor to MA 2 retaliating. The longer the relationship lasted the less tolerant MA 2 appears to have been of MA 1's behaviour. The escalation in domestic abuse appears to have coincided with an increase in their alcohol consumption, although it is very difficult to be precise. It also appears that MA 1 was the more able and dominant of the pair. There was also a suspicion in some agencies that MA 1 stayed with MA 2 because of the financial benefits it brought to MA 1.

7.7 Their alcohol abuse turned into chronic dependency and agencies never established its exact association with domestic abuse. MA 1's period under probation's statutory supervision included an Alcohol Treatment Requirement. However, attendance this did not alter his behaviour.

7.8 The quality of the domestic abuse risk assessments undertaken was variable and limited to three agencies. On the one occasion a domestic abuse, stalking and harassment risk assessment [DASH] was completed it revealed that MA 1 presented a high risk of causing serious harm to MA 2. That initiated the MARAC process, the outcome of which did not address MA 1 and MA 2's problems. The cumulative effect of domestic abuse on MA 2 in particular, does not seem to have been properly considered when assessing risk. Some practitioners did not have the training, knowledge or awareness to pass on their concerns to an agency who would have completed a risk assessment.

7.9 Apart from the MARAC process and that was limited, no other framework for dealing with the complex domestic abuse issues between MA 1 and MA 2 was considered. Agencies should have explored the adult safeguarding route which may well have provided a model within which to support the couple. MA 2's case should have progressed to a vulnerable adult strategy meeting. Another option was for a manager within one of the agencies involved with MA 1 and MA 2 to have used their influence and drawn together a multi-agency meeting to respond to the matters. The outcome of such a meeting would have included: the appointment of a lead professional; establishing aims and objectives; developing and implementing a practical plan together with a separate written safety plan for MA 1 and MA 2. One professional suggested this approach but it never happened. A more remote possibility was to have the case screened for access to the Multi Agency Public Protection Arrangements [MAPPA].

7.10 Nevertheless professionals worked hard to effect change in MA 1 and MA 2 and there was some good collaboration between agencies; there was significant sharing of information, apart from with their GPs.

7.11 MA 1 and MA 2's unpredictable response to offers of help and support did not instil confidence in professionals. One summed it up by saying, "I felt a bit deflated, I was encouraged by all the interagency work" and "MA 2's drinking was out of control but nobody appears to be supporting him. I felt if all these specialist agencies could not help him, how could I"?

7.12 2011 saw a spike in the reported domestic abuse between MA 1 and MA 2 which tapered off during mid-2012. The chronology shows that MA 1 and MA 2 had very complex needs but no sustained motivation to accept help.

7.13 In late 2012 the abuse increased continuing into 2013 and the fatal incident. As late as mid-August 2013 MA 2 said he feared for his life and thought MA 1 might stab him.

7.14 Whether the problems of MA 1 and MA 2 were solvable, controllable or containable will never been known for a fact. The barriers they faced and erected effectively kept professionals at bay. The DHR Panel thought that given both men were adults with the mental capacity to make their decisions, it was not perhaps for others to impose a moral judgement about their

behaviour; rather it was to try and keep them safe from harm within the restrictions of their choices and the law. The ability of agencies to safeguard adults who have mental capacity contrasts sharply with children's safeguarding where the legislative framework enables professionals to take effective action without consent.

7.15 The DHR Panel's overall conclusion was that the complexities of MA 1 and MA 2's long established relationship and their variable tolerance of professionals, coupled with their dependency on alcohol, made it very difficult to provide them with help and support in a way that had an enduring and positive impact on their live

8. LESSONS IDENTIFIED

8.1 The IMR agencies lessons are not repeated here because they appear as actions in the Action Plan at Appendix A.

8.2 The DHR Lessons Identified are:

1. Only three organisations completed domestic abuse risk assessment. South Yorkshire Police and South Yorkshire Probation Trust used the domestic abuse risk assessments current to them and Choices and Options completed a DASH Risk Assessment. Other agencies had opportunities to complete risk assessments but did not. A reasonable conclusion is that risk assessment in domestic abuse cases is not embedded within all relevant agencies in Rotherham.

   Lesson

   If domestic abuse risk assessments are not completed, victims are denied the opportunity to have the risks they face from perpetrators systematically scrutinised and protective measures put in place. In brief victims continue to be exposed to unknown and therefore uncontrolled risks.

2. The domestic abuse between MA 1 and MA 2 continued unabated and peaked in 2011 and 2013. Many agencies knew of the situation but no one took responsibility for organising a multi-agency response and appointing a lead professional, thereby relying on a more ad-hoc approach organised by professionals working in ones or twos.

   Lesson

   Repeat victims who do not meet the qualifying criteria to receive support from MARAC, MAPPA or Vulnerable Adult processes have no framework within which their cases can be considered, thereby leaving them without effective coordinated services.

3. The DHR Panel was unable to tell from the IMRs or its debates exactly what it was that MA 1 and MA 2 wanted from their lives. MA 1 and MA 2 moved from one crisis to another and were inconsistent in asking for and accepting help and support; additionally they sometimes actively resisted the offers made to them. Therefore, it is reasonable to say that professionals would also struggle to know what the couple required. Professionals also overlooked the Respect screening tool for determining who the victim/perpetrator was. Overall professionals had no clear idea what is was that MA 1 and MA 2 wanted from them and this made planning and delivering life changing outcomes so much harder.

   Lesson

   Professionals working complex domestic abuse cases should establish who the victim/perpetrator is and want they want and then agree aims and objectives with them. This will provide professionals with a clear operating framework.

4. Sometimes GPs are the only agency to know when a patient is the victim or perpetrator of domestic abuse and therefore they have an important role to play in supporting their patients. In this case, most agencies did not tell either MA 1 or MA 2's GPs, about the domestic abuse. The information that was shared was not pursued by the GPs and the earlier recommendation for GPs to adopt the SRP GP flow chart should help them to support victims and perpetrators.

   Lesson

   If professionals do not share information with GPs about their patients who are involved in domestic abuse it leaves a gap in the resources available to support victims and perpetrators.

5. For much of the review period agencies had very limited experience of dealing with domestic abuse in a male same sex relationship and probably less experience or knowledge of what bespoke services were available. That improved from 2012 but by then the pattern and depth of abuse between MA 1 and MA 2 was firmly set.

   Lesson

   Professionals should recognise that domestic abuse features in same sex relationships as it does in heterosexual ones, and requires specialist support for victims and perpetrators.

6. MA 1 and MA 2's abusive relationship was widely known about. Many professionals approached it from a male/female model of dealing with domestic abuse, overlooking the fact that it was male same sex domestic violence.

   Lesson

   The traditional male/female model of dealing with domestic abuse does not necessarily suit male on male long term domestic abuse.

Professionals should be mindful of this point and tailor their methods accordingly.

7. The limited experience of professionals in dealing with male same sex domestic abuse and the paucity of specialist resources, particularly before 2012, meant that the reason for MA 1 and MA 2's behaviour was not fully understood. Part of an effective plan for dealing with domestic abuse is to establish and deal with the causes.

   Lesson

   Without understanding the reasons for MA 1 and MA 2's mutually abusive relationship, the likelihood of success in reducing or eliminating it was significantly reduced.

8. Not understanding what drove the domestic abuse meant that professionals had a lesser chance of reducing or eliminating it. Individual professionals working with MA 1 and MA 2 received supervision and management, but the need for strategic direction of the case was never identified or pursued by managers or MARAC.

   Lesson

   Failing to recognise that this case required strategic direction meant that the chance of a successful outcome was significantly reduced.

9. Adult services acted promptly and stopped MA 1 financially exploiting his mother. They did not consider that MA 1 might transfer his exploitation to another person, in this case MA 2.

Lesson

Professionals should be mindful that people, who have been stopped from financially exploiting one person, may look for others to exploit and take action to prevent or minimise it happening.

10. The DHR Panel felt that in general agencies domestic abuse policies could be seen as focussing on heterosexual domestic abuse.

Lesson

Operating within a heterosexual domestic abuse model makes it more difficult to identify same sex domestic abuse and provide appropriate support.

11. There was significant confusion in many agencies on when and how to refer MA 1 and/or MA 2 to adult safeguarding and several agencies missed opportunities to do so.

Lesson

Without referrals adult safeguarding is unable to support victims of domestic violence and lessen the risks they face.

9. PREDICTABILITY/PREVENTABILITY

9.1 It was known that MA 1 caused serious harm to MA 2 as evidenced by his conviction and imprisonment in 1986 for stabbing him. The DHR Panel assessed that MA 1 continued to pose a high risk of causing serious harm to MA 2.

9.2 However, no risk assessment was completed that suggested MA 2 posed a risk of causing serious harm to MA 1 and in that context his action in killing MA 1 was not predictable.

9.3 The DHR Panel [and MA 1's sister] observed a change in the dynamics of the relationship after MA 2's brain injury in 2007. MA 1 continued to abuse MA 2, but MA 2 began to retaliate and became a perpetrator. For example in April 2011 MA 1 received treatment in hospital for two fracture fingers which he said were inflicted by MA 2. That incident and another assault on MA 1 by MA 2 in August 2012 were risked assessed by SYP who determined that MA 2 posed a medium risk of causing serious harm to MA 1.

9.4 The increase in violence between MA 1 and MA 2 took place in an environment where both men were dependent on alcohol. They had mental health needs but were not suffering from a mental disorder. However the risk assessments did not reflect the actual dangers each posed to the other.

9.5 It was MA 2 who took MA 1's life and the Crown's decision to accept MA 2's plea to manslaughter reflects the DHR Panel's view that MA 2 probably responded to his long term victimisation and momentarily lost control with fatal consequences.

9.6 Therefore, the DHR Panel believed the death of MA 1 was not predictable nor was it preventable.

10. RECOMMENDATIONS

10.1 Single Agency

10.1.1 The single agency recommendations appear in the Action Plan and are not repeated here.

10.2 DHR Panel

10.2.1 The DHR Panel recommends that the Safer Rotherham Partnership:

1. Satisfies itself that its constituent agencies domestic abuse policies explicitly cater for abuse within LGBT relationships.

2. Establishes a common domestic abuse risk assessment model across it constituent agencies

3. Ensures that professionals in its constituent agencies are fully conversant with the services available to LGBT victims and perpetrators and how and when to make referrals.

4. Identifies what services are available for LGBT victims and perpetrators of domestic abuse and if there is a gap, how best new services can be commissioned.

5. Reviews the current domestic abuse framework to ensure it includes a mechanism to identify those complex cases which are not supported by the current domestic abuse framework and thereafter satisfies itself that services are available for such victims and perpetrators.

6. Considers the benefits of its constituent agencies having a common understanding of the various definitions associated with vulnerable adults and how to apply them to individual cases, including on when and how to make safeguarding referrals.

7. Determines whether there are benefits in its constituent agencies using the same documentation for making safeguarding referrals.

8. Determines whether its constituent agencies understand the adult safeguarding procedures and how they relate to domestic violence processes including MARAC.

9. Ensures its domestic abuse training includes: LGBT domestic abuse as a substantive element and the Relate "Male victims of domestic violence screening tool kit". Additionally, supervisors should receive training in the MAPAC process.

10. Includes in its domestic abuse training the phenomenon of transfer of risk [including financial risk] from one victim to another.

11. Encourages its constituent agencies to share domestic abuse information with the victims and perpetrators' GPs.

12. Establishes how best GPs can contribute to supporting victims and perpetrators of domestic abuse, including supporting MARAC and using the SRP GP domestic abuse Flow Chart.

13. Reviews the MARAC Minute template against the CAADA minute template to ensure the former incorporates the key features of the latter.

14. Invite CAAADA to audit the SRP 2013 CAADA self-assessment Action Plan.

15. Supports Headway in developing and introducing its domestic abuse policy and support training.

Appendix A

DEFINITIONS

Domestic Violence

The Government definition of domestic violence against both men and women [agreed in 2004] was:

"Any incident of threatening behaviour, violence or abuse [psychological, physical, sexual, financial or emotional] between adults who are or have been intimate partners or family members, regardless of gender or sexuality"

The definition of domestic violence and abuse as amended by Home Office Circular 003/2013 came into force on 14.02.2013 is:

"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

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 a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

Therefore, the experiences of MA 1 fell within the various descriptions of domestic violence and abuse. SRP preference is the term Domestic Abuse which is used in the report hereafter.

Vulnerable Adult [No Secrets 2000]

The broad definition of a 'vulnerable adult' referred to in the 1997 Consultation Paper Who decides? * issued by the Lord Chancellor's Department, is a person:

"Who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation".