EXECUTIVE SUMMARY

DOMESTIC HOMICIDE REVIEW

in respect of

The Victim

Born 1941

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EXECUTIVE SUMMARY

This domestic homicide review was commissioned by Tamworth Community Safety Partnership to enable lessons to be learned from the death of a white British man who died at his home in May 2014. His son pleaded guilty to manslaughter and he was sentenced to seven years' imprisonment.

The review followed the statutory guidance for conducting domestic homicide reviews and individual management reviews were sought from all those agencies that had contact with either the victim or the perpetrator – namely, police, health, adult safeguarding, home care, domestic abuse services and local authority housing. Information was also provided by children's social care and youth offending services.

The panel consisted of senior managers from Staffordshire County Council's children and adult social care, police, youth offending, health, local domestic abuse services, the clinical commissioning group and the community safety partnership. The review focussed on events between January 2008 and the victim's death in May 2014. However, the review also outlined some relevant events dating back to the perpetrator's childhood.

The review revealed that the family was large, chaotic and known to many agencies. The father (victim) had a history of violence. This included violence against his wife and children, as well as violence outside of the family home. A number of incidents involved his son (perpetrator) such as the father hitting him with a hammer. According to family members, the son telephoned children's social care aged seven and asked to be taken into care. Following child protection concerns, the son (aged nine) became "looked after" under s.20 Children Act 1989.

The son had sporadic contact with his family whilst in care. Then in 2008 aged 15½, he informed children's social care that he wished to live with his step-sister on a permanent basis. Following various arrangements, he ended up living with his father again, whose health by this time had deteriorated. During the period under review, the father sustained a number of injuries including fractures to both his hips. However, it was not until 2013 that family members alleged that his daughter had caused these injuries.

There were a number of occasions when police were called to the property. These incidents concerned issues such as damage to property, anti-social behaviour, disputes with neighbours and disputes within the family over money. These incidents often involved alcohol or drugs. Frequently allegations were retracted or family members would not want further action taken. On occasions, the father was the instigator and on others, he was the victim.

As the father's health deteriorated, he was supported with domiciliary care but the daily visits stopped in January 2013 when he moved in with his stepdaughter and her husband. At the same time, an adult protection referral was made to Staffordshire County Council following information from his stepdaughter's husband about bruising on her father's arms. There followed two adult safeguarding investigations. One by the local adult social care team (medium risk) and one by the adult protection investigation team (high risk). However, on both occasions, despite clear allegations of physical and financial abuse, the father did not want the issues investigated further or retracted the allegations. Both cases were closed and no further action was taken, as the allegations were considered "unsubstantiated".

Around Christmas 2013, the father left his stepdaughter's house and went to stay with his daughter at her property. The daughter was then evicted from her property and thus she and her father moved into the one-bedroomed flat that his son shared with his girlfriend.

In late May 2014, an ambulance was called to the flat where they all lived. The father appeared to have died from injuries sustained during an assault. It became apparent during the murder investigation that the father had inherited about £25,000 and this was a source of conflict between his children.

The review highlighted a number of issues including the importance of understanding the effect of domestic abuse on children. Inevitably, many children growing up in a household where domestic abuse is commonplace will be affected by the experience, and they may carry this experience into their adult lives.

It also became clear that some organisations had limited understanding of domestic abuse involving vulnerable adults. Practitioners failed to make appropriate referrals instead they focussed on whether the father had mental capacity rather than viewing him as a victim of domestic abuse. This case demonstrates that practitioners continue to view domestic violence and abuse as an issue affecting partners in an intimate relationship, and thus sometimes overlook violence and abuse that may occur between children and their parents.

The lack of communication had a direct impact on the amount of information known about the father to individual agencies.

The recommendations from the review are:

- Staffordshire County Council should invite a domestic violence specialist worker to all meetings concerning adults at risk of neglect and abuse where domestic abuse is identified

- Staffordshire County Council and Staffordshire and Stoke on Trent Adult Safeguarding Partnership Board should ensure that adult safeguarding awareness training includes domestic abuse to (amongst other things):
    - Equip staff to recognise that the definition of domestic abuse also encompasses those adults who are abused by their children and/or other family members
    - Ensure staff are able to assess the risk to victims of domestic abuse
    - Enable staff to know how and when to refer victims of domestic abuse to specialist domestic abuse services or appropriate partner agencies
- Staffordshire County Council and Staffordshire and Stoke on Trent Adult Safeguarding Partnership Board should ensure that training on the Mental Capacity Act, adult safeguarding awareness training and training on legislation all emphasise the reasons for not over relying on mental capacity
- Where there are integrated teams, Staffordshire and Stoke on Trent Partnership NHS Trust should consider introducing an integrated case recording system that can be accessed by all health and social care staff within the Partnership
- Staffordshire County Council together with the Adult Safeguarding Board should ensure that all statutory adult safeguarding enquiries involve multi-agency strategy discussions. This should include discussion about the suitability of potential carers from within the household or family
- West Midlands Ambulance Service should consider developing a system that will enable searches to be made by patients' names as well as by addresses.

In conclusion, the father's family was large, chaotic and the majority of the individuals were known to a significant number of services and agencies. The family had a long history of violence, domestic abuse, and drug and alcohol use that spanned the generations. Furthermore, it appeared that family members took money from one another if the opportunity arose. When family members fell out, they often moved accommodation. This inhibited agencies' ability to monitor where the father was living which manifested as a problem as he became more vulnerable.

Although the father did at times disclose historic financial and physical abuse, he often retracted the allegations or declined to take the issue further. Equally, when he did disclose, practitioners failed to recognise his vulnerability and make the appropriate referrals. While there were a couple of opportunities to potentially intervene to remove the father from the exploitative situation in which he found

himself, there was nothing to indicate that his son might murder him. Thus, the panel concluded that this domestic homicide was neither predictable nor preventable.