Safer North Tyneside

Community Safety Partnership

Domestic Homicide Review

Executive Summary

Domestic Homicide Review- Executive Summary

Sammy

Review Chair

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Completed

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Foreword : Sammy's Brother

My name is Eddie and I am Sammy's brother. We came from a family of eight, four brothers and three sisters and we were brought up by our Mam. Our Father was never at home. It was hard for Mam to keep us all together but she did her best and struggled with the help of her sister and her brother-in-law. We lived in Noble Street flats and it was a task in itself just to survive. Our older brother was a Father figure in our lives and we looked up to him for a time until he raised his hands to me because I didnt do what he wanted. That was when I realised he was using us for his own means. I was 10 or 11 when I turned to crime just to make sure we had a meal and a roof over our heads and then Sammy followed me. He was sent to a school in Wales and I later found out from the police that he had been abused there, he was never the same again.

Sammy was good with his hands and could fix anything but he didn't learn to read or write. He worked in a scrap yard and kept parts to build things like bikes. He could strip an engine and our neighbours often called on him to help out. He met his partner and they had two children, things were going well until he started using cannabis, this led to him and his partner arguing a lot and the kids ended up in care.

Sammy started living on the streets. One day he turned up at my house and I told him to have a bath and gave him clothes and I let him stay at my house. He stayed for seven years and he would tell me everything. He then met a woman and moved in with her, I wished him well. His partner liked to drink and it wasn't long before he lost the flat due to anti-social behaviour and he moved back in with me. I dont know where his partner went.

Sammmy then left again and I thought he was living in a flat in Walker. I then found out he had met Allison and was living in Zach's house. I didn't see much of him at this time but he did come to my house one day and I helped him. He had a pocket of tab ends he had got from the street and was in a bad way – dirty and unkempt. This wasn't like Sammy; he took a lot of pride usually and liked to look good. He had a bath and Zach rang him. I picked up the phone and he thought I was Sammy, he started shouting at me saying 'you better get back here now'. I told him I was Sammy's brother and Sammy could do what he liked and didn't have to do what he said. Sammy shrugged this off when I told him.

I didn’t see Sammy again. I tried to call him and a woman answered the phone and said it wasn’t Sammy’s phone. Not long after this the police came and told me they had found his body. I was devastated, I broke down. I sat every day at the trial and I now suffer from PTSD, asthma and COPD and heart problems.

People have said my brother was vulnerable after he was killed, I want to know why no one recgonised that he was vulnerable before he died. We had social services involved in our entire childhoods and as an adult, social services took Sammy’s two kids. People knew he was vulnerable because they were involved with him. That might have helped him and a protection order should have been put on him. I think the services think that people like me and Sammy are scum of the earth and not worth helping. I got no help afterwards, a few sessions with Victim Support then they didnt get back to me. I was offered therapy but it had to be at a police station – why? I dont sleep, I have nighmares and I need answers - why did they do this to my brother? I know I won’t get the answers I need.

Sammy has sons and I am in contact with one of them, he also has grandkids and they need answers too.

1.0 The Review Process

This summary outlines the process undertaken by Safer North Tyneside Community Safety Partnership's Domestic Homicide Review Panel in reviewing the homicide of Sammy who was a resident in their area.

This Domestic Homicide Review is highly unusual and complex. It is a review of agency responses and support given to **Sammy**, prior to his death. Sammy was 43 years old when he was murdered. His body lay concealed on waste ground near the house(s) he shared with four others. He was not discovered for some weeks and during this time the people he lived with continued to take money from his bank account. Following the recovery of his body a complex investigation took place and all four members of the households he lived in received significant prison sentences, **two members Zach and Allison for his murder and a further two Karen and Mary for causing or allowing harm to be caused of a vulnerable person.**

The trial uncovered a catalogue of abuse, violence, exploitation, and torture that Sammy had been subjected to over a sustained period of time. The trial attracted widespread media coverage both locally and nationally and the level of detail in the public domain has caused great distress to the family. The murder of Sammy is truly abhorrent, killed by people he believed to be his friends, this report therefore makes for very difficult reading and contains direct reference to rape, sexual violence, abuse and torture.

The review considered contact and involvement with Sammy and the perpetrators from September 2012 until Sammy's death in February 2016. This period was chosen as this defined what the panel knew of the relationship from agency records and family testimony. Some background information prior to 2015 is also used in the report for context.

The homicide was reported to the Chair of the local Community Safety Partnership (CSP) which is known as the Safer North Tyneside Board (SNTB) in line with the agreed local protocol on the 11th April 2016 and the decision to undertake a DHR was made by the SNTB following a scoping exercise (known as a DHR Core Group) on the 26th April 2016. The Home Office were duly notified on the same day of the intention to undertake a DHR.

The review recommenced following the outcome of the trial in May 2017. The panel then met on six further occasions. Agencies submitted their IMR's in 2018. The first draft overview report, authored by Richard Burrows, was presented to the panel in February 2020. The panel was then put into abeyance. This is explained in detail in the Overview Report.

In January 2021, the SNTB appointed an Officer to lead a recovery group on its behalf to ensure the DHR was completed. This small group developed a recovery plan and sought guidance to shape the approach with support from Lesley Storey. Specifically, work was conducted to engage with the family and build relationships promoting partnership. The involvement of family is a central requirement in the DHR process and much work was conducted to ensure the family were placed in a central position. Their input and guidance has been invaluable and the DHR process is richer as a result. The DHR Panel would like to offer their condolences to Sammy's family.

The recommendations agreed by the panel members and their respective agencies seek to make improvements to future access to services and to professional practice to make sure that lessons are learned from Sammy's homicide. Sammy's family have expressed their main concern now is that no other person should have to endure the abuse and torment Sammy experienced.

It has not been possible to complete this DHR with full compliance to the timescales set out in the Statutory Guidance. All agencies participating in this review have implemented actions identified from each agency IMR in a timely manner immediately following the homicide.

The SNTB continues to learn and improve and acknowledges that changes are needed to the management of DHR's. A responsible officer has been identified to oversee future DHRs and ensure statutory deadlines are met.

2.0 Terms of Reference

2.1 The purpose of a DHR [1] is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisation's 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 inform national and local policies and procedures as appropriate.
- Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a coordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.
- Contribute to a better understanding of the nature of domestic violence and abuse; and highlight good practice.

3.0 Contributors to the review / Agencies submitting IMR's.

Table 1 shows the agencies who contributed to the DHR process.

Table 1

Agency	Panel Member
North Tyneside Clinical Commissioning Group	Dr Riaan Swanepoel, GP Child and Adult Safeguarding Lead

[1] (Multi-Agency Statutory guidance for the conduct of Domestic Homicide Reviews 2016 section 2 paragraph 7)

Northumberland, Tyne and Wear NHS Foundation Trust	Leesa Stephenson, Safeguarding and Public Protection Manager, Independent panel member, Sheona Duffy, Acting Team Manager Safeguarding and Public Protection/Named Nurse (from 2018)
Northumbria Health Care NHS Foundation Trust	Lauraine Gibson, Matron Paula Shandran Head of Safeguarding (Children & Adults) and Acute Liaison Learning Disability (from 2019),
Northumbria Police	Eric Myers, Detective Chief Inspector, Safeguarding Louise Cass Williams Detective Chief Inspector, Safeguarding (from 2021)
North Tyneside Council Adult Social Care (from 2018)	Ellie Anderson, Assistant Director Business & Quality Assurance
Community Rehabilitation Company	Joanne Wallace, Reviewing & Quality Assurance Manager Steven Gilbert, PDU Lead – North Tyneside and Northumberland PDU (from 2021)
Department for Works and Pensions	Philip Trenbrith, Senior Operations Manager Lyndsey Thornton, Advanced Customer Support Team Leader (from 2021)

Safer North Tyneside	Janine Charlton, Community Safety Officer

4.0 Review Panel Members

Table 2 shows the agencies who sat on the DHR Review Panel.

Table 2

Agency	**Panel Member**
North Tyneside Clinical Commissioning Group	Dr Riaan Swanepoel, GP Child and Adult Safeguarding Lead
Northumberland, Tyne and Wear NHS Foundation Trust	Leesa Stephenson, Safeguarding and Public Protection Manager, Independent panel member, Sheona Duffy, Acting Team Manager Safeguarding and Public Protection/Named Nurse (from 2018)
Northumbria Health Care NHS Foundation Trust	Lauraine Gibson, Matron Paula Shandran Head of Safeguarding (Children & Adults) and Acute Liaison Learning Disability (from 2019),
Northumbria Police	Eric Myers, Detective Chief Inspector, Safeguarding Louise Cass Williams Detective Chief Inspector, Safeguarding (from 2021)
North Tyneside Council Adult Social Care (from 2018)	Ellie Anderson, Assistant Director Business & Quality Assurance

Community Rehabilitation Company	Joanne Wallace, Reviewing & Quality Assurance Manager Steven Gilbert, PDU Lead – North Tyneside and Northumberland PDU (from 2021)
Department for Works and Pensions	Philip Trenbrith, Senior Operations Manager Lyndsey Thornton, Advanced Customer Support Team Leader (from 2021)
Safer North Tyneside	Janine Charlton, Community Safety Officer

5.0 Author and Chair of the overview report

Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016 sets out the requirements for review chairs and authors. In this case the chair and author were the same person until January 2021.

Richard Burrows is an independent chair and reviewer who has practiced independently for over 10 years. Richard wrote the first report then assumed the role of Chair solely from 2021.

Lesley Storey assumed role of Author in 2021 following a request by the commissioning CSP to review and make changes to the layout and structure of the initial report. The first report was then rewritten. Lesley is the sole Author of this report, she has no direct connection with any of the agencies involved in the review. Lesley has extensive experience in the field of domestic abuse and has -

- Completed the Home Office online training on Domestic Homicide Reviews, including the additional modules on chairing reviews and producing overview reports

- Completed DHR Chair Training (Two days) provided by AAFDA (Advocacy After Fatal Domestic Abuse)
- Attended training on the statutory guidance update in 2016
- Attended the AAFDA Annual Conference (March 2017)

6.0 Summary Chronology

September 2012	Sammy moves into the household's owned by Karen. Zach is living in household A Sammy moves into household B. Prior to this Sammy's last known address was his mothers, it is likely Sammy had been homeless for some time including street homeless before moving into property B.
February 2013	A woman called Mary becomes involved with the properties owned by Karen and moves into property B with Sammy. Mary becomes Zach partner having met him online. Mary had recently left prison having been arrested for fraud by false representation in her position as an informal carer for which she was sentenced to sixteen weeks in prison.
March 2013	Sammy is recorded by DWP as being the carer for Zach. This was an informal arrangement which was not recognised by ASC however the panel were provided with intelligence that Zach referred to Sammy as his carer and allocated caring tasks to him.
May 2013	Sammy was brought into A&E by police, he reported he had been assaulted and kicked in the head. He had treatment to his ear, and it was recorded he had had a loss of consciousness. Sammy did not disclose who had assaulted him.
June 2013	The Police are contacted by a neighbour of household A and B, they report Zach is being abusive to them, and that Sammy is threatening them with violence. This is later resolved as a verbal argument only and no further action is taken by the police.

November 2013	Sammy and Zach have an altercation with a neighbour, this is reported to the police but is not recorded as a crime. The neighbour reports that Sammy has tried to hit him. On further investigation the incident is downgraded to a verbal argument by both parties and no further action is taken by the police.
January 2014	Sammy is spoken to by police on the way to Allison's home, he is noted to be with Allison's brother Ian. This is the first record of Ian's involvement with Sammy.
July 2014	Sammy and Ian are both charged with theft from charity shops.
August 2014	Zach the perpetrator is the victim of fraud by his corporate appointee. Harassment, property vandalism and an actual physical assault are also reported to the police, Zach is alleged to be the victim from neighbours and persons unknown.
September 2014	Hate crime toward Zach from neighbours is reported to the police.
March 2015	The first record of Allison moving into household A occurs at this time, she contacts the DWP and registers a claim for her and her partner Sammy. Very soon after she moves in Sammy reports that a caravan outside the property has been set on fire and the perpetrator is alleged to be Ian Allison's Brother.
April 2015	Allison contacts North Tyneside Council to ask for welfare assistance stating she had moved from Newcastle to live with her partner Sammy, she was claiming Employment Support Allowance and the couple were advised to make a joint claim with Sammy being added to her claim. Staff contacted the DWP to ascertain the status of the claim and made a referral into a food bank for the couple. Two weeks later Sammy and Allison report to the police that Ian has made threats to them and has kept Allison's benefit which was paid into his account. Allison is assessed as a victim of domestic abuse using the DASH and categorised as a standard risk victim the perpetrator recorded as Ian. A phone

call later the same day is recorded by the police in which Allison states the money situation is now sorted out. The Police ask to follow up with Allison on the threats she had disclosed and make diary appointment to see her. On attendance at the property, Allison and Sammy refused the police entry and explained that they had evicted Ian.

A week later a further report is made of Ian taking the couples' benefits, Ian makes threats to Allison and Allison reports this to the Police.

May 2015	Allison attends a planned health appointment and discloses she has been receiving death threats. A safeguarding adult form was raised in respect of the concerns raised alongside a referral to the Community Learning Disability Team (CLDT) due to concerns Allison presented as a woman with "comprehension difficulties". A social worker makes contact with Allison to discuss her worries and concerns, Allison reported being too unwell to speak and that there were other people present that she could not speak in front of. ASC decide to take no further action at this point as Allison is being managed by the CLDT.
September 2015	Allison attends her GP with her landlady (assumed to be Karen and this was later verified by Allison when interviewed by the Author). It was reported that Allison had fallen out with her brother Ian – 'he has been aggressive and has been threatening her.' It was also reported that the Police have been involved and Ian has now left the area. During the consultation Allison also disclosed she was also having difficulties with her boyfriend a man called Sammy and he had forced her to have sex with him. They were now separated, but still living in shared accommodation. It was also recorded that an ex-boyfriend (name unknown) was blackmailing Allison and asking her for sex and threatening to

speak to the Job Centre so she will lose her benefits. She stated he had forced himself on her, but she will not go to the police as he has threatened her that she will lose her home and benefits. Allison consents to a referral being made to ASC but she is very clear she does not want the police to be informed. No Domestic Abuse Risk Identification (DASH RIC) is completed with Allison by either the GP or the Social Worker.

October 2015 Allison attended her GP for a sick note and agreed to a referral to CLDT to meet at surgery. It is recorded she is still living with Sammy, but she is happy with this situation. Several attempts are made by the CLDT to try and make contact with Allison, but all are unsuccessful.

November 2015 The Police contacted by a local hospital as Sammy is in attendance with wounds from a knife and reporting he was attacked with a baseball bat 9 days prior to attending hospital. He had extensive bruising to his upper body, a dislocated shoulder and four stab wounds one of which is on his scrotum. Sammy stated that Ian was one of the attackers, Karen is with Sammy and corroborates this. The cause of the attack was reported as being as a result of Sammy ending the relationship with Allison. Sammy left hospital and returned to the household of Zach and Karen. No ASC referral was raised by either the hospital or police and no DASH Form was completed with Sammy despite his stating the attack had happened as a result of him ending a relationship and the alleged attacker was his partners Brother.

Later in November Sammy attends his GP and all the residents of both household A and B were in attendance at the appointment. Zach did most of the talking and the others were mostly silent. The GP was informed by Zach that Sammy had been assaulted, Sammy knew who the attacker was but would not say this to the police. It was recorded that Sammy had extensive bruising on his face and upper body. Despite the

	chaotic nature of the consultation no safeguarding alert was made and the GP did not ask the others to leave so Sammy could be spoken to alone.
December 2015	Allison reported to the police that Ian was sending her death threats through third parties, a statement was provided, and an arrest package was prepared in respect of Ian. No DASH was undertaken with Allison and no safeguarding alert was submitted to ASC. No evidence was presented that the police had conducted threats to life risk assessment to mitigate/manage the risk. Sammy attends his GP practice and again all four members of the household come into the consultation room. The GP noted there appeared to be a dramatic decline in Sammy since the assault. Zach again said that everyone around him knows who assaulted him, but he will not tell the police. The GP referred him to CLDT for assessment and support. No safeguarding alert was raised, and again, Sammy was not seen on his own. A multi-disciplinary meeting (MDT) is arranged by the ASC LD Social Worker. It was disclosed that Allison had been contacted on 3 separate occasions by CLDT following a referral from the GP. On checking the case notes it was highlighted that Allison had disclosed to the GP and a social worker that she had been coerced by her partner to engage in sexual activity against her will. The follow up to this disclosure had been via a phone call and Allison had declined further support. Due to Allison declining support the original safeguarding alert was closed. It was agreed a safeguarding strategy meeting was required. Immediate actions identified to safeguard Allison were not followed through from this meeting. Towards the end of December (22.12.15) Allison reported to the police that her brother had threatened to kill her via a third party. On the same day, the CDLT sent out an appointment for Sammy. No DASH

	is undertaken with Allison and no safeguarding alert is submitted. Visits by the CLDT are undertaken to Allison's and Sammy's home on two separate occasions for both parties, no engagement is made with either party. On 30.12.15 Sammy (or a man who states he is Sammy) calls ASC and tells the service he is feeling harassed with the constant phone call and visits, he is explicit in saying he does not want help or support.
January 2016	A safeguarding strategy meeting is held in respect of Allison Concerns are expressed that Sammy may be being coerced/controlled by others and there are also concerns about his involvement in criminal activity. The GP shared that Sammy had attended the surgery covered in bruises and that he had been accompanied by three people on all occasions he was seen. The GP advised that Sammy has no formal diagnosis of learning disability but the GP who saw him felt he was functioning as though has a degree of learning disability. The code adult safeguarding concern was added to his GP records.

7.0 Key Issues/Themes Arising from the Review

The key issues and themes arising from this review can be summarised as follows-

Key Finding One

Communities hold important information in relation to preventing abuse of vulnerable people but may not understand how to recognise when something is wrong or know how to raise alerts.

This review highlighted a complex context of Anti-Social Behavior, Hate Crime and Neighbour Disputes which appears to have masked significant safeguarding concerns. As a result, no member of the community raised alerts for Sammy despite a serious decline in his physical presentation.

Key Finding Two

Safeguarding alerts were not made in respect of vulnerable adults.

Opportunities for single agencies to undertake further enquiry and make safeguarding alerts were identified through -

- GP appointments
- A&E Attendances following assaults
- Interviews with Northumbria Police

No agency made a safeguarding alert for Sammy at any point in the timeframe of this review therefore Sammy had no specific contact with ASC in his own right.

Key Finding Three

Perpetrators of abuse used professional's appointments/meetings to reinforce control.

It is well documented that perpetrators of domestic abuse control their victims through following them to appointments and insist on attending appointments and it is therefore best practice to seek to speak to people alone whenever possible. This did not happen and as a result Sammy did not have the opportunity to speak to professionals at any point during the timeframe of the review on his own.

Key Finding Four

Perpetrators manipulated professionals.

The review uncovered a systematic and persistent pattern of perpetrators controlling systems that are in place to safeguard victims. It is well documented that motivated perpetrators **seek to manipulate professionals and systems established to assist victims to exit abuse**[2]. Zach very clearly and skilfully used other victims, professionals, systems, and processes to amplify his control. He was able to disarm

[2] https://safeandtogetherinstitute.com/season-2-episode-5-how-professionals-can-avoid-being-manipulated-by-perpetrators

and deflect attention from the risk Sammy's was exposed to by creating a focus on Allison and her risk from Sammy.

Key Finding Five

Adult Safeguarding Arrangements lacked clarity and urgency.

The Safeguarding response does not appear to have been effectively coordinated or overseen at a multi-agency level, and as a result, opportunities were missed to see Sammy as a potential victim of abuse. There was a confused approach to the implementation of adult protection arrangements. Signs that Sammy was being abused and exploited were missed as a direct result of the late formation of safeguarding strategy meetings.

Key Finding Six

Record keeping in relation to multi-agency safeguarding meetings was inadequate.

In undertaking this review the Author found evidence that record keeping, and information sharing fell below standards expected in safeguarding.

Key Finding Seven

Actions from Strategy Meetings were not carried out.

The Author was not able to determine if this related to Key Finding 6 in that the professionals involved where not tasked with actions or were unaware actions had been requested because of poor information sharing.

Key Finding Eight

Concepts of Self Determination and intervening without consent requires further analysis at an inter-agency level.

Autonomy as a principle is deeply embedded in codes of professional ethics and in legislation – respecting this is both morally right and lawfully right. Sometimes however a complex situation requires a more nuanced understanding of the factors that can lead an individual declining help.

A key theme that that arose in both the under reporting of safeguarding concerns and decisions about progressing referrals in multi-agency safeguarding

arrangements related to consent and a laudable wish for the person to self-determine how they managed their safety. The review uncovered a perception in some services that consent took primacy over information sharing in respect of sexual offences.

Key Finding Nine

The Focus on Learning Disabilities may have obscured a more holistic understanding of wider risk.

The review found that there was a consistent theme of the focus of attention being placed on the assessment of learning disabilities. This was problematic for two key reasons, firstly the terminology and definition of "Learning Disability" can be confusing and potentially stigmatising. Professionals need to have a clearer consideration of the view of individuals who may be very concerned about the perceived stigma of being labelled with a learning disability. Learning Disability may not be a neutral definition, it may come loaded with a negative or even derogatory meaning for many people. Sammy specifically may have viewed this as disempowering.

Secondly attention on the issues of Learning Disability detracted focus from the wider safeguarding concerns and may have delayed agencies from forming a more holistic understanding of wider risks.

Key Finding Ten

Financial abuse was not recognised as significant factor by agencies.

The levels and extent of economic abuse uncovered in this review were significant and substantial. It was extremely difficult to gain a full picture of who was financially abusing whom as there were multiple strands, multiple perpetrators and this pattern shifted over time. Financial exploitation of adults is a serious issue and indicator of harm and risk. It is the view of the Author that agencies were not sufficiently sighted on this as an indicator of harm and more needs to be done to ensure agencies see financial abuse as a clear indicator of significant harm.

Key Finding Eleven

Agencies did not consistently screen, or risk assess for domestic abuse using the DASH therefore opportunities to make referral to MARAC were missed.

There was evidence through the review that risk assessment in relation to domestic abuse was inconsistent. Northumbria Police were the only agency that used the DASH RIC however there was also evidence this tool was applied inconsistently by attending officers. This is a consistent theme across DHRs both in Northumbria and Nationally.

Key Finding Twelve

Services appear to have been blind sighted by a binary narrative that people are either victims or perpetrators.

Sammy was not identified as a possible victim of abuse and exploitation. Sammy was instead viewed as a perpetrator of domestic abuse, and this obscured services ability to see his vulnerabilities and that he was also a victim of abuse and exploitation. There were indicators Sammy was an adult at risk of harm; his presentation had deteriorated, he was dirty and disheveled, he had lost weight, he had lost teeth, and he had visible bruising yet despite this his vulnerability as not recognized. No single agency had a full picture of what was happening in Sammy's life and there were several missed opportunities for initiating safeguarding procedures, assessments, or other interventions and for agencies to share information. It is the view of the Author that Sammy was not considered vulnerable or at risk of harm as services viewed him as a perpetrator of domestic abuse rather than a potential victim.

Key Finding Thirteen

Disclosures of Rape and Sexual Exploitation were not recognised as indicators of high-risk and were therefore not shared in a multi-agency context in a timely fashion.

Rape/sexual abuse and exploitation were significant themes throughout this review and though the examination of these themes it has been highlighted there is a significant shortfall in agencies understanding and awareness of risk in relation to rape and sexual exploitation.

Key Finding Fourteen

Vulnerable Adults need enhanced support following a disclosure of rape/sexual exploitation.

Evidence consistently highlights Adults with Learning Disabilities are at increased risk of repeat incidences of rape and sexual assault/exploitation. Despite this Allison was not provided with information/advice or referral into a specialist sexual violence service such as Rape Crisis or ISVA Service. Independent Sexual Violence Advisers play a hugely important role in supporting victims of rape and sexual violence. They are victim-focused advocates that work with people who have experienced sexual violence to access the services they need. All victims should be offered this service and particular attention should be given to ensuring adults who may have additional needs are considered.

Key Finding Fifteen

Services were not aware of the impact of trauma.

The impact of trauma is still not well understood, and agencies could not identify or recognise trauma responses' complex contributory factors. By adopting a trauma lens, agencies can start to build a picture of what might be underlying issues resulting from trauma rather than viewing someone as non-engaging or resistant to receiving services. As example framing an understanding of Sammy as a man who “wants to engage with services as he isn’t yet ready to trust, rather than “Sammy has a history of not engaging”. Sammy couldn’t speak out as he was too afraid of the consequences. Even towards the end of his life, when his physical condition deteriorated, trauma and fear prevented him from speaking out.

Key Finding Sixteen

Non-Engagement with services was a key theme in this review and neither Sammy nor Alison was ready to trust and engage with the services offered to them.

This is a common thematic area arising in DHRs both locally and nationally.

Key Finding Seventeen

Professional curiosity was lacking across all agencies involved in this review.

Professional curiosity is the capacity and communication skill to explore and understand what is happening with an individual or family. It is about enquiring deeper and using proactive questioning and challenge. It is about understanding one’s responsibility and knowing when to act, rather than making assumptions or

taking things at face value. Sadly, across all agencies who took part in this review very few examples could be found of agencies looking beyond what was presented to them eve when at times the presentations were highly unusual. This is a recurring theme both locally and nationally across all safeguarding reviews.

8.0 Conclusions

The main conclusions and key lessons arising from Sammy's case and agreed by the DHR Panel are as follows:

Sammy was subject to significant physical abuse that could more accurately be described as torture. He was subjected to acts of humiliation and degradation which included sexual abuse and extreme physical abuse. He was financially exploited and deprived of his human rights and liberty. Although the abuse was happening in plain sight of the local community and in some cases, services, alerts were not raised.

There were multiple barriers which prevented Sammy from seeking support, he was highly controlled and accompanied to GP visits, and he was also the suspect of offences against another vulnerable person and was being assessed through this lens. This context did not enable a safe space for Sammy to talk.

Sammy's life story as a child in care who had been abused and as an adult who had an extensive history of being involved with the criminal justice system also created barriers. Sammy was unlikely to have trust in statutory services.

Sammy experienced multiple disadvantages (categorised as a combination of problems including homelessness, substance misuse, contact with the criminal justice system and mental ill health), and this required a multi-agency response sensitive to his needs and personal history of trauma. The panel reflected at length on the opportunities Sammy had to speak out about the abuse or for services to recognise the abuse. Five clear opportunities were identified (the attendance at A&E, the contact with Northumbria Police regarding the assault and the three GP appointments).

In addition, there were missed opportunities to safeguard Sammy through the multi-agency frameworks MARAC and Safeguarding Adults, although he would have been defined as a perpetrator this would still have enabled professionals to share information and consider risk in its widest context.

9.0 Recommendations

Based on the chronology, analysis and conclusions of the Overview Report, the DHR Panel agreed a series of recommendations for national, regional and local bodies to help prevent future domestic homicides. Sammy's family have endorsed support for these recommendations.

System
The MASH takes forward the learning from this report ensuring Multi-Agency Safeguarding meetings are convened when the critical threshold is achieved.
All services to be undertake refresher adult safeguarding training to include domestic abuse awareness, managing difficult situations and a reminder of current polices and procedure. Critically this training should reinforce the importance of ensuring adult safeguarding alerts are raised at each and every possible opportunity.
All agencies are requested to consider policies, practice and procedures in relation to individuals who present with potential learning disabilities/complex needs. Accessible services for all and appropriate to address the actual safeguarding concern.
All agencies should ensure that practitioners receive training on policies and procedures to ensure the right referral pathways are used.
All agencies to consider the learning from the development of domestic abuse systems and processes in which it is clear, even if the victim does not consent to a referral into MARAC risk levels can override the need to gain consent.
Raise awareness in recognizing and responding to financial abuse in staff across agencies.
All agencies should give immediate consideration to the terms "perpetrator" and "victim" how these concepts are assessed and recorded within systems reflecting on current best practice and research.

All agencies to initiate a DASH on receiving a disclosure of abuse
Trauma informed responses to be integral to the whole safeguarding system.
Multi-Agency Safeguarding meetings to have a set template for minutes and to record clear outcomes and actions. The minutes should set out who is Chair and timescales for achieving actions /outcomes.
Every victim should have access to an ISVA following a sexual assault, regardless of whether they choose to report their abuse to the police.
All agencies to review policies, procedures, and staff training in relation to recognising and responding to economic abuse.

Single Agency
ASC should ensure that disclosures of rape and sexual abuse/exploitation by adults with vulnerabilities'/complex needs are assessed as high risk triggering a professional's strategy meeting to include criminal justice representation and specialist support.

Strategic Partnerships
The SAB should use learning from this DHR to further develop the safeguarding pathway for non-engaging, capacitous adults to include- • Understanding responses to coercion and control and the barriers people may face in accepting support. • Recognising circumstances where public interests require involvement of the Police and the Community Safety Partnership. • Developing single and multi-agency safeguarding responses to non-engaging adults that demonstrate defensible practice, balancing the Safeguarding Adult Principles of empowerment, proportionality, protection

and accountability. This pathway should be supported by training, guidance and tools to aid practice. • Learning from partnership responses to domestic abuse may be useful in developing this work.
The SNTB should use the learning from this DHR to further develop the safeguarding pathways for victims of Mate Crime/Hate Crime /Modern Day Slavery, specific emphasis should be paced on ensuring- • Development of third-party reporting mechanisms that are located in communities • Community awareness campaign Developing Trauma Informed responses across services
Communities need clear messages that spell out signs of abuse and exploitation and critically how to raise concerns. It is recommended that the SNTB works with the DAP and the SAB to educate and mobilise communities to recognise, and report concerns in relation to vulnerable people through awareness raising campaigns.
The SNTB should seek assurances from agencies (via strategic Partnership arrangements) that their current policies, procedures and practices support the education and awareness campaigns to enable clear reporting and response.
Community safety strategies should explicitly address disability-based harassment, hate or mate crime and exploitation.
SNTB to seek reassurance from all partners that services have in place policies /procedures for the management and promotion of safe environments to enable disclosures of abuse.
Perpetrators’ manipulation of systems must be recognised as part of a wider pattern of control. SNTB to develop and deliver training that specifically focuses on perpetrators manipulation of professional and systems.

The SAB should seek assurances around embedding the learning from this review in its governance and quality assurance role.
SNTB to seek assurances that multi-agency meetings have effective administration procedures in place.
The SNTB should raise the issue around the lack of definition available in circumstances that justify or require intervention by a state agency without consent at a national level.
Partnerships should explore a more coordinated approach to addressing economic abuse.
SNTB will develop a training programme and guidance information on Professional Curiosity which will be available to all agencies including the charity, community, and faith sectors. All agencies to review improved understanding of professional curiosity in supervision.