Safer North Tyneside
Community Safety Partnership

Domestic Homicide Review

Executive Summary

Dean

Review Chair
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Foreword by Dean's Family

Dean was a much-loved son, he lived with me for much of his life including as an adult and I am heartbroken I could not save him, I tried and I couldn't. Dean was extremely clever, articulate when he was able to set his thoughts out in writing and he loved reading. He was gentle but could at times, when he was drinking, be very sarcastic. He was not violent I cannot, we cannot, imagine him hitting anyone.

As a family we took a Civil Action out against Northumbria Police, we didn't care about the money but we believe our son would be alive today if measures had been put in place to prevent James walking out of hospital, free to go to our son's house and kill him. Had conditions been attached to James's bail ensuring the safeguarding of our son he would be alive. It is not right that following an extremely serious assault no bail conditions were applied to James, the sanctions applied to him were throughout the relationship far lower than those applied to Dean. We cannot understand why despite the information available Dean was not viewed as vulnerable and needing safeguarding.

Article 2 of the European Convention on Human rights imposes a sanction on the state to protect human life –this includes in certain circumstances a positive duty to protect life. In failing to put adequate safeguarding measures in place Northumbria Police, in our view, failed in their duty. The court did not find fully in our favour and we accept this. [1]Our beliefs however remain unchanged.

We want to ensure that no other family suffers as we have and that gay men are recognised as victims and that those who suffer from alcoholism are not written off – they are as deserving of support as every other victim. Dean was extremely vulnerable, because of his social phobia, because of his alcoholism, because he was gay man. We feel this was not recognised.

We were all glad when Dean met James, we welcomed James into our family and we were relieved because he seemed to be someone who would help, love, and support my son. James told us he was a pharmacist and he was retraining to be a drugs counsellor; he showed me his training certificates. We believed him. It wasn't until our son's death we found out the truth and that James had told many lies.

[1] This is the view of the family.

James was a practiced liar and he had us all fooled, he groomed us into thinking he was a good person and we trusted our son with him. James lived with me when he first came to the North East, I supported Dean and James to get a lovely flat together, I helped them, and we all did.

Dean had struggled with an extreme social phobia from around the age of 15. He was very shy and hated social situations where there were more than a few people around, especially if he didn't know them. Over the years this grew worse and he masked his shyness with alcohol. Alcohol allowed him to be able to be more social, go for a drink with his Dad, speak to friends. Sadly, the alcohol took over and the crutch became more of a problem than the shyness. His health suffered and he became drink dependent. Dean had wanted to have residential detoxes to help him but the thought of being around others in this type of situation terrified him.

Dean met James through an online support group for alcoholics. James was older, more confident and at the time we met him he didn't appear to be drinking. I thought this was a good sign. Dean had been very lonely, he desperately wanted to be in a happy loving relationship, to be part of a couple and to have a normal life. Being in a settled relationship was very important to him and once he met James, he was committed to ensuring this relationship lasted.

Dean came to stay with me many times during the relationship when the police asked him to leave for the night following a row. I would be woken up in the middle of the night sometimes by the police sometimes just Dean, he would tell me James was at it again. I knew this to mean hurting him but I didn't understand for a long time – months - how bad this was. Dean was drunk on these occasions and he wasn't always clear about what had happened. He may not always have known what was going on due to the drinking.

When James was asked to leave, he had nowhere else to go so would just leave for an hour then go straight back. He once went to a friend's home.

I gradually grew to understand more when Dean was sent to prison for 5 days for breaching his bail his solicitor was very good and I started to understand he was being controlled and abused. I also knew Dean was so in love and so wanted to make the relationship work he would have done anything to keep James and that included taking the blame. Dean was very clear; James had a career ahead of him

and Dean wanted to ensure this wasn't impacted by a criminal record. Furthermore, he loved him so much he wasn't going to end the relationship.

Our son had a health condition that meant he was often in pain, the injuries he suffered meant he was often in huge amounts of pain. I watched him one day helping James with a box trying to get it into a car, James made him do this and as I looked out, I could see the pain on Dean's face and that he couldn't move his arm fully.

We understood from Dean's solicitor he had a stab wound on his body when he was arrested for breaching his bail conditions. We want to know why this wasn't recognised or taken into account by the police.[2] We also found out from Dean that on one occasion James locked himself in the bathroom after assaulting our son. The police came and James scratched his own face and said Dean had attacked him. Dean felt powerless to defend himself and to speak out, his social phobia and fear of strangers would not have helped him speak out either.

Nothing I, his Dad or his Brother could say was going to help change Dean's mind about reporting James. We loved him and we wanted to support him as much as we could. Dean also made excuses for James's behaviour and said it happened when he was drunk and he was nice when sober. As an alcoholic Dean had great empathy for James's behaviours when he was drunk. James was controlling when he was sober though – violent when drunk, controlling when sober. Dean didn't understand this fully.

It was devastating when he went to prison and I cried every day most days. I knew how gentle he was and I worried he would be hurt or would hurt himself as he struggled to be in that situation with lots of strangers. Luckily, he was put in a cell with an older man who was kind to him. Even being in this terrible situation didn't change Dean's mind about James.

Dean was always very afraid James would sleep with other men. James threatened to do this and it was one of the reasons Dean broke his bail conditions; he needed to be back with him as he was so worried James had other men.

[2] This question was addressed within Northumbria Police IMR

Dean also said James had everyone wrapped around his little finger and so no one would believe him if he told the truth about what was happening. Dean was right, no one did believe my son - one police officer seemed to understand near the end but mainly no one listened when he did try to speak.

James also kept Dean without money, he controlled all the finances. Dean wasn't allowed to have his bank card – James kept this. I often gave him money, I hated doing this as I knew he would buy alcohol but I worried about what would happen if he didn't have money and what James would do to him. The rent didn't get paid and food wasn't a priority, although Dean had used food banks at times – any money went on drink.

Dean's Dad said that James wouldn't let Dean watch TV unless he had subtitles on, he couldn't have the sound on. James smashed his tablet so Dean couldn't have contact with the hundreds of friends he had on social media.

On the final day of his life Dean was attacked, stripped naked and left for dead by James on the floor while he went out for a drink. Dean's clothes, the ones he had been wearing that day were in the washing machine. James said he did this as my son had messed himself after falling over; he told lies about him even at the very end.

Dean's Brother

Dean's younger Brother was aged 20 and a student at the time Dean met James. He was so happy for his brother he did everything he could to support the couple including driving down to Blackpool to collect James from the hostel he was living in to drive him up to the North East.

From the very start Dean confided in his Brother and Dean started to share photographs of his bruises from assaults from James on a regular basis. Dean sent photographs of bruising on his arms, his face, all over his body with messages that said, '*look what happened tonight he's off on it again'*. These messages and images were viewed by the Independent Author.

Dean's brother tried to support him, he encouraged him to report this to the police and to tell them what was really happening. On one occasion he rang the police and

an ambulance as he was so afraid Dean was going to be seriously hurt. Dean also sent other photographs of his bruises in a file with the message, *'I'm sending you all the evidence in case he destroys it'.*

When Dean died, a previous boyfriend of James's made contact and told Dean's Brother that James had abused him, raped him, and told lies about him and that he felt lucky to be alive.

Dean's family are united in the very strong feeling that not enough support or understanding is available for gay men. The police didn't seem to understand or care what was happening and were entirely focused on believing James. No support that is specific to gay men was offered to Dean and they felt if that had been available, Dean might have talked to someone about what was happening to him. The family want to see training for the police and other agencies about how domestic abuse can impact on men and appropriate support offered to victims.

1.0 The Review Process

1.1 This summary outlines the process undertaken by the Safer North Tyneside Community Safety Partnership Domestic Homicide Review (DHR) panel in reviewing the homicide of Dean who was a resident in their area. Dean was a gay man who was killed by his partner James*[3]. Dean was subject to a brutal attack in September 2016, he was admitted to hospital and later died from head trauma injuries. On the 28th April 2017 James was convicted of manslaughter and sentenced to 7 and a half years imprisonment, with an extended license of three years and six months as the Judge considered him to be dangerous to any future partners.

1.2 The review considered contact and involvement with Dean and James from December 2015 until Dean's death in September 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.

1.3 The DHR Panel would like to offer their condolences to Dean's family on their tragic loss. 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 Dean's experience.

1.4 The process began with an initial meeting of the Community Safety Partnership (CSP) which is known as the Safer North Tyneside Board (SNTB) in line with the agreed local protocol on the 13th September 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 6th October 2016. The Home Office were duly notified on the same day of the intention to undertake a DHR. All agencies that potentially had contact with the victim and perpetrator prior to the point of death were contacted and asked to confirm whether they were involved with them.

[3] James is a pseudonym

1.5 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.

1.6 The review commenced following the outcome of James' trial. Agencies submitted their IMR's in 2017. There was a significant volume of information to review in terms of chronology and detail in the IMR's, the review process was complex. Progress with the review was affected further due to a period of illness for the Chair and a draft report was received by panel members in October 2019 and considered at the November panel meeting. A second draft was circulated to panel members in February 2020. The report went to Panel members but the response to the Covid 19 pandemic meant that further work was regrettably delayed.

1.7 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 [4] 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.

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

- 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.

2.2 Some case specific terms were used to ask a specific set of questions to panel members when conducting their Independent Management Review (IMR). The IMR analysis, in addition to the general guidance set out in Appendix A in the overview report, should specifically address the following:

- If there was a low level of contact (*or no contact)* with your agency why was this so?
- Were there any barriers (particularly ethnic origin, ***sexual identity**,* culture or language) to either the victim or the accused accessing your services and seeking support?
- Was there indication of the victim being isolated *or* ***controlled/coerced*** by the accused and could this have prevented them from contacting services?
- Were there any other issues relating to this case such as **drug or alcohol abuse** and if so, what support was provided (victim and perpetrator)?
- Whether the perpetrator **had a history of any violent behavior** and if any referrals were made to services in light of this?
- Whether any **risk assessments** had been undertaken previously on the victim or accused and whether these had **judged risk appropriately?**
- Whether the victim was experiencing **coercive control** on the part of the accused?
- Was there any indication of domestic violence or coercive control occurring before the incident and if so, did the victim consider this to be control or domestic abuse?

- Do you hold any information offered by informal *and or social networks?* The victim or accused may have made a disclosure to a friend, family member or community member.
- To what extent did contact and involvement with the victim and/or accused result in a formal or informal assessment of the wider family including any children or young people?
- Did the victims, origin, ***sexual identity*** culture or language impact on access to services or service delivery?
- Consider whether involvement was consistent with

    (a) Professional standards and

    (b) Compliant with its own protocols, guidelines, policies and procedures *including multi agency policies and procedures*

3.0 Contributors to the review / Agencies submitting IMR's

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

Table 1

Agency	Contribution
North Tyneside Clinical Commissioning Group	IMR
Northumbria Police	IMR
North East Ambulance Service NHS Trust	IMR
Northumberland, Tyne and Wear NHS Foundation Trust	IMR
Northumbria Health Care NHS Foundation Trust	IMR
North Tyneside Council Adult Social Care	IMR
Harbour	IMR
North Tyneside Council Housing Department	Record Search
Department of Work and Pensions	Record Search

Victim's First Northumbria	Record Search and chronology

3.2 In addition to the agencies that were asked to complete a chronology and Individual Management Report, there have also been contributions and contact with North Tyneside Council Housing Department, the Department of Work and Pensions and the Northumberland and North Tyneside Domestic Abuse Coordinator.

4.0 Review Panel Members

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

Table 2

Agency	Panel Member
North Tyneside Clinical Commissioning Group	Adrian Dracup, Designated Nurse Safeguarding Adults
Northumberland, Tyne and Wear NHS Foundation Trust	Leesa Stephenson, Safeguarding and Public Protection Manager/Named Nurse Sheona Duffy (from 2021), Acting Team Manager Safeguarding and Public Protection/Named Nurse
Northumbria Health Care NHS Foundation Trust	Lauraine Gibson, Matron Paula Shandran (from 2019), Head of Safeguarding (Children & Adults) and Acute Liaison Learning Disability
North East Ambulance Service NHS Trust	Stephen Downs, Safeguarding Adult Advisor

	James Killgallon, Safeguarding Adult Advisor
Northumbria Police	Eric Myers, Detective Chief Inspector, Safeguarding Louise Cass Williams (from 2021), Detective Chief Inspector, Safeguarding
North Tyneside Council Adult Social Care (from 2018)	Ellie Anderson, Assistant Director Business & Quality Assurance
Safer North Tyneside	Janine Charlton, Community Safety Officer
Independent Chair	Richard Burrows

4.2 It is acknowledged that the panel membership is narrow and restricted to statutory agencies, this has been a point of learning for the CSP and is reflected in the key findings section of this report.

4.3 The report Author also identified that both parties may have self-presented to a neighbouring hospital trust. However, this was not clarified through chronologies or IMR's. The Author thinks that the Panel and subsequent review process would have benefitted from obtaining confirmation of any contact from other health trusts.

5.0 Author and Chair of the overview report

5.1 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.

5.2 Richard Burrows is an independent chair and reviewer who has practiced independently for over 10 years. He was the Chair of the Local Children's Safeguarding Board until September 2019. Richard works as an Advisor for three safeguarding statutory partners, the Local Authority, the Clinical Commissioning Group and Northumbria Police. Richard wrote the first report then assumed the role of Chair solely from January 2021.

5.3 Lesley Storey assumed role of Author in late January 2021 following a request by the commissioning Safer North Tyneside Partnership to review and make changes to the layout and structure of the initial report. The first report was rewritten and during this process significant gaps in the review were identified. Two additional agencies Harbour and Adult Social Care were subsequently requested to provide IMR's. Additionally, following re-engagement with the family significant new information was provided. 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

Dean and James meet through an online self-help group called Smart Recovery Network[5] for people with alcohol and drugs addictions in the Autumn of 2015. They very quickly fell in love and James was supported by Dean and his family to move to the area Dean had lived in for most of his life

[5] A registered national charity which promotes mutual aid support for people with addictions

and close to his family. James told Dean he was a recovering alcoholic, abstaining from alcohol and now a counselor who helped others with their recovery.

James was warmly welcomed into Dean's family, he lived with Dean at Dean's Mother home for a period of time and then, with the family's help, the couple moved into a flat of their own.

The relationship very quickly escalated to one in which **abuse, coercive control and physical violence** became on ongoing feature. This was set against a backdrop of **alcohol misuse** as both parties were **drink dependent,** this had been an ongoing condition in both men throughout their adult lives.

In December 2015 the first report of domestic abuse is recorded when James contacted the North East Ambulance Service (NEAS) reporting that **Dean had injured himself when assaulting James**. The police were called by NEAS and Dean informed them he had been assaulted by James three days earlier and his shoulder was injured. The Police assessed this incident as standard risk and James was arrested on suspicion of assault (Section 47).

Days later there was a further incident and James contacted the Police to state that Dean was "kicking off again". On attendance by the police both parties were found to be intoxicated and James was assessed as a standard risk victim. This then set an established pattern in which James would call the police and say Dean had assaulted him.

January 2016

In January 2016 **Dean started to confide in his Brother about what was happening and the abuse he was experiencing.** Dean sent a text to his brother stating he was terrified of James and that he had everyone wrapped around his little finger. An image came with the text of Dean with **significant bruising on his arm.**

On the 6th January 2016 James was admitted to hospital for an overdose and was seen by the psychiatric liaison team. James was aggressive to attending NEAS staff and a call was made to the police for assistance. Dean came on

the phone and **told the police his partner had assaulted him on a previous night**, he had **tried to end the relationship and James had taken an overdose.**

During the assessment that took place by the psychiatric liaison team, James reported his partner had left him and the overdose was as a result of this. He also stated his partner **Dean was abusing him as he was openly drinking in front of him** when he knew James was trying to control his alcohol use. James was seen by a Social Worker who gave information and helpline advice for a male victims' support service.

On the 21st January 2016 **James contacted the Police reporting that Dean had assaulted him.** He made a subsequent call to retract but the correct procedure was followed to attend to the first call. It was noted that **Dean came onto the phone to make a counter allegation of assault by James**. James was categorised as the victim and assessed as standard risk.

February 2016

On 24th February 2016 Dean sees his **GP who asks him about the domestic abuse** and Dean reports he is still sober. His GP continues management of pain relief for shoulder.

On the 27th February 2016 Dean contacted the Police reporting that James was in psychosis and had barricaded himself in his room. On attendance both were found to be intoxicated and it was established that no physical assault had taken place. An argument had occurred, James claimed to have withdrawn to the bathroom and said that Dean contacted the Police to antagonise the situation. As a result, **James was assessed as a 'standard risk' victim** and his support and safeguarding needs were passed to the Neighbourhood Policing Team for monitoring.

On the 28th February 2016 **James contacted the Police reporting that Dean had gone for him with a knife.** Dean was arrested, detained overnight in police custody and subsequently charged with a Section 47 assault.

As a result of this incident Dean was granted conditional bail until June, he was not to contact James and was to reside with his mother. If he needed to enter the flat they had joint tenancy of, then this should be in the company of a police officer. A restraining order was also applied for.

March 2016

On the 9th March 2016 James reported to the Police that Dean was at the flat they had shared and therefore in breach of his bail conditions. He claimed that **Dean had punched him in the eye and caused damage to the living room.** James also refused to complete a DASH RIC but the risk level was raised to 'high' on professional judgement. A referral was made into MARAC and into the commissioned IDVA service operated by Harbour.

Dean was arrested, taken to court and released with the same conditions. Dean then went to a meeting with an addiction service and was allocated a key worker from the North Tyneside Recovery Partnership (NTRP). **Dean informs his key worker that he is fearful of his partner and has significant injuries,** he describes a situation in which his **partner controls the use of electricity in the home and regularly attacks** him when he is drunk. Dean also states that he **takes the blame when the police are called** as his partner works as a Carer and he does not want domestic abuse to appear on his Disclosure and Barring Service (DBS) record. Dean is referred to Harbour and to a counselling service. No Adult Safeguarding referrals are made, and no risk assessment is undertaken.

Later in the day Dean was further arrested for breach of his bail conditions as he phoned James. Dean was escorted to court; his bail was revoked and he was **remanded in in Durham prison** until 15th March 2016. Information from the staff escorting Dean recorded he had been extremely distressed in the court cells.

April 2016

In April 2016 the **first MARAC took place**, Dean was identified as a perpetrator of domestic violence and involved agencies were required to "flag and tag" him, so that when future contacts took place agencies would be aware.

On the 6th April 2016 James attended the magistrate's court and Dean was released from custody. This resulted in the Crown Prosecution Service (CPS) discontinuing the case and bail conditions were cancelled.

On 12th April 2016 James has been made aware by the GP Practice that he is required to register with another GP practice due to his high levels of non-attendance at appointments. On the same day Dean speaks with a GP from the Practice, as he thinks he has another broken rib as a result of his partner hitting him. The GP advises Dean to report his partner to the police but **does not give advice or information about any other support or undertake an assessment of risk.**

On 14th April 2016 Dean has an appointment with the same GP he spoke with on 12th April 2016. **He reports his partner has hit him again.** The GP understands that police have been involved recently, and suggests Dean considers moving in with his Mother but Dean refuses to do so.

On the 20th April 2016 Dean calls the GP Practice and speaks with a GP. Dean is concerned about his chest infection. Dean attends an appointment later in the day and is recorded as being intoxicated, **Dean was examined, and Dean showed a bruise and a bite mark to his GP. Dean reports that his partner has previously taking his pain relief.** Dean refers to an assault and police involvement in the past week.

May 2016

On the 9th May 2016 Dean contacted the Police reporting that **James had taken an overdose after an argument.** On attendance all was calm and it was established that an argument had occurred. As a result, **James was assessed to be of standard risk.**

On the 11th May 2016 James speaks to his GP and Dean becomes a part of the telephone call. There is a further call that day when both James and Dean are spoken with and both are intoxicated. James reports he is seeing cockroaches and is aware he needs help with his alcoholism but feels services are "a waste of time". James states that he feels it is **Dean's fault he is hallucinating as he hasn't been waking him up every two hours to**

have a drink of alcohol. He says he has read that this is what he needs to do to avoid withdrawal, he says he will overdose, and Dean is advised to call an ambulance if he does.

On the 17th May 2016 the GP Practice writes to the relevant health authority to request the removal of James from their list as they felt he had breached the conditions previously agreed. On the same day **Dean is seen by the addictions service and they make a referral to a food bank for him.**

On the 18th May 2016 Dean contacted James's addictions worker. He asked for advice as his partner was hallucinating, taking large amounts of "street" diazepam, including 4 overdoses and that he was increasingly threatening Dean.

On the 19th May 2016 James contacted the Crisis team to complain that he had been waiting all night for a visit from them. **James stated he would kill himself or his partner** and that he had PTSD (Post Traumatic Stress Disorder), he was ex-forces, and that he was depressed. There does not appear to have been any assessment of the risk James posed to his partner or himself.

On the 24th May 2016 **James contacted the Police to report a domestic assault by Dean.** Shortly afterwards James called the Police again to say that there had not been an assault and that he was detoxing. Police attended and established both James and Dean were intoxicated and that they had been arguing. Dean was advised and agreed to leave the premises for the night. **James was assessed as a high-risk victim.**

On the same day, Dean contacted his brother to say, "**I'm sending you these photos and videos in case James deletes them"**. Included with the text was a folder containing **13 images and videos of Dean with bruising on his face, body and limbs.**

On the 25th May 2016 James was contacted by a Domestic Violence Officer (DVO) and this resulted in James declining any safety planning. James later made contact with the Police reporting that **Dean was being verbally threatening** to him, he also alleged that **Dean had struck him on the cheek resulting in a graze**. As a result, **Dean was arrested on suspicion of**

assault. James subsequently contacted the Police to retract his complaint resulting in no further action against Dean.

On the same day, Dean sent a text to his brother with an **image of extensive bruising to his arm and stomach from an assault on him by James**. His brother responded to the image with the message *"I'm worried he is going to kill you one day".*

June 2016

In June 2016 James rang Dean's GP practice in an attempt to get medication, which he said was on Dean's behalf. He was verbally abusive to the receptionist stating, "I am a patient at this surgery, and I will fucking seek you out goodbye". The police were called, and Dean was informed he would be removed from the practice list.

On 4th June Dean sent a text to his brother that stated **James had taken his tablet from him and wasn't allowing him to watch TV**. He also sent an image of his arm which showed **bruising and clear grab marks**.

On the 6th June 2016 Dean was sent a letter informing him that he had been removed from the from the practice list.

On the 14th June 2016 **James was discussed at MARAC** as a result of the 3 further incidents since the last MARAC on 5th April 2016.

On the 17th June 2016 James contacted the Police to report that **Dean had assaulted him** and was refusing to leave. On attendance both were found to be heavily intoxicated. Dean had allegedly scratched James on the stomach while pushing him away in an argument. James refused to make a complaint and Dean agreed to be taken to his Mother's for the night.

Later that night James re-contacted the Police to say that Dean had returned and was argumentative. James made 2 subsequent calls having said he would not let any attending officers in and to state he had taken medication and was hallucinating and then to say that Dean had assaulted him. (All 3 calls were within a 2-hour time span).

On the second attendance by police **Dean was returned to his mothers. James was assessed as high risk.**

July 2016

On the 9th July 2016 **Dean made a 999 call into the Ambulance Service,** he said he had been **assaulted 3 days earlier** and was clammy and vomiting. A nurse called back approximately 20 minutes later and spoke to Dean, he stated he had **bruises all over his body**, he had **broken ribs** and his breathing was getting worse and he was in severe pain. James called the ambulance service at 12.45hrs with stomach pain.

The police then attending found both Dean and James saying they had been **assaulted by the other**. James **was admitted to hospital with severe alcohol withdrawal**. He was noted as being intoxicated and stating he wanted to walk out under a car.

Both allegations were recorded as crimes then closed as undetected and no further action was taken. Dean indicated that they had both been drinking heavily and that physical assaults had occurred**. It was noted that Dean had bruises.**

On the 9th July 2016 A&E made a PROTECT referral for James into ASC, James consented to this as he feels unsafe at home.

On 12th July 2016 James was discharged from hospital. ASC were informed he was being discharged. On the same day, the MARAC took place and two actions were recorded; that the landlord of the joint property be contacted to establish if any measures could be put in place and to try and find alternative accommodation for either party as it was believed the risk would be reduced if they were separated. Harbour closed James's file as they had been unable to contact him.

Also, on the 13th July 2016 James informed the DVO that he and Dean were back together and that he was not willing to provide any information in regard to the landlord, but that the landlord was aware of the DV incidents.

On the 17th July 2016 James contacted the Police stating that **Dean had hit him on the head and was being verbally abusive**. On attendance James explained events as being as a result of his attempts to help Dean with detoxing. He refused to make a complaint or supply a statement. Dean was escorted to his Mother's house. This was registered as a crime; **James was assessed as high risk.**

On 21st July 2016 both Dean and James were spoken to by a DVO and a referral was also made to the Independent Domestic Violence Advisor (IDVA) for James. Dean said he was willing to accept any help for them to work through their problems.

August 2016

On the 4thAugust 2016, James attended A&E having been brought by the Police as he had called them to state Dean was being abusive. He reported abdominal pain but was discharged as being medically fit. He disclosed that he was a victim of domestic abuse and that he needed help to detox.

On the 9th August 2016 a MARAC meeting took place, the records noted two actions for Northumbria Police –to update the victim of the MARAC and to encourage both parties to engage with alcohol services.

On the 18th August 2016 a partially completed 999 call resulted in attendance by the ambulance service and police. James said Dean had hit him in the face then gone for him with a statue. James had been able to prevent further blows and attributed the friction between them to the attempts they were making to reduce their alcohol consumption. **Dean was arrested on suspicion of assault,** he collapsed when he arrived at custody and was transferred to hospital. **Dean asked the hospital to write a note for him that outlined to his partner he was at risk of withdrawal if he didn't keep drinking**.

On the 19th August 2016 the DVO contacted James, he said he was unsure about supporting a prosecution as he wanted to remain in the relationship.

The DVO advised on cocoon watch[6] options and James reported that the neighbours were aware of the abuse.

On the 26th August 2016 James contacted the Police saying that Dean was at the property and had assaulted him. Dean was arrested on suspicion of assault and then released, as no complaint was made. James remained high-risk. Later that night an ambulance was called, and police were also in attendance as James was unconscious.

James was seen by a doctor and treated for alcohol withdrawal, he said he was suicidal and had tried to jump in front of a metro train a few days before. He also said his boyfriend was trying to cut him off from his family and friends. James received treatment for alcohol withdrawal over a five-day period.

On 31st during this stay in hospital a PROTECT referral was made to Adult Safeguarding as James looked as if he had neglected himself and was unkempt. He had a bite mark on his shoulder and alleged that his partner had cancelled an ambulance after James had experienced a seizure.

September 2016

On the 1st September 2016 Dean visited James in hospital and was observed to be intoxicated. Dean was asked to leave.

On the 3rd September 2016 James called the Police stating he had a knife and was going to kill himself. On attendance, after a forced entry to the premises James was apprehended unarmed. **Dean was observed to have heavy bruising by police staff who attended this incident**. He disclosed that **James had assaulted him multiple times in the preceding three da**ys, and that James was **controlling him and withholding things from him**. He also reported that **James had attempted to stab himself in the leg.** Officers called an ambulance, but Dean refused treatment; he also said he did not want to make a complaint. **Dean was assessed as medium risk.**

[6] A Cocoon Watch" scheme, is where friends and neighbours can be asked to keep an eye on them and call police if they have concerns regarding safety.

James was arrested for assault and was taken into custody; no custody record was taken in accordance with the Police and Criminal Evidence Act (PACE) and this was to have significant consequences in the chain of events that then took place. Whilst under arrest James had a seizure which required him being taken to A&E. He was later transferred to another hospital for treatment relating to his sudden alcohol withdrawal, James remained in hospital under arrest with Police officers present.

Later that day, the hospital advised that James could not be released and needed to remain in hospital for three days. This presented a challenge for Northumbria Police as due to James's arrest status he was required to have a police officer with him at all times. The failure of custody staff to create a custody record for James meant that the later decision to grant him bail fell to a response Sergeant, rather than a trained custody officer.

The escorting officer was directed by a supervising officer to use 'street bail'[7] to release James from police custody and due to a human error, no conditions were placed on James preventing him from approaching Dean and no safeguarding measures were put in place. James subsequently discharged himself from hospital.

On the 6th September 2016 a MARAC took place where James was discussed as the victim. There is no record that evidences that the very serious assault by James on Dean was discussed.

On the 7th September 2016 James was arrested and **charged with a Section 18 assault** from the incident on the 3rd September 2016.

Dean died shortly afterwards.

7.0 Key Issues/Themes Arising from the Review

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

[7] When a person who is arrested can be given bail before they arrive at a police station. This is called 'street bail'. The arresting officer must give the person a 'bail notice' which states that they must return to a specified police station, on a specific date and time.

- **Managing counter-allegations and identifying risk** - The panel were clear and united in the view that all professionals and agencies involved in this case lacked skills, experience, and the necessary tools to identify who was causing harm to whom.
- **Professional Curiosity** - There were clear missed opportunities for ALL agencies to undertake further questioning and assessment of the dynamics of the relationship. Agencies accepted at face value James' narrative and version of events seemingly uncritically and at times with absolute acceptance, this significantly increased risk to Dean.
- **Risk Assessment** - The panel concurred that the current risk assessment tool, the DASH Risk Indicator Checklist, could be more accurately described as a risk screening tool rather than risk identification tool. Furthermore, the DASH lacks rigour in identifying risk in same sex couples. Specifically, in this case the Author also identified occasions in which the DASH Risk Indicator Checklist was not completed correctly and occasions in which professional judgement could have been used to escalate Dean to medium and high risk.
- **Alcohol and substance misuse** – Alcohol and substance misuse issues were extensive and longstanding for both parties. Agencies were focused on managing risk in the context of alcohol misuse but failed to assess and therefore understand the impact alcohol had on the level of risk.
- **Information sharing in the context of multi-agency working and MARAC** - The MARAC meeting did not facilitate accurate and timely information sharing. Opportunities to refer into MARAC were missed and the MARAC process was ineffective in managing risk.
- **Information Management** - During the review it was identified that IT systems and case management systems were changed (Harbour, Victims First Nothumbria, and Adult Social Care) and therefore information was lost and/or referrals may not have been received. A key lesson for agencies from the review is to consider the impact of system changes and the methods and process for ensuring that data is not lost.
- **Barriers in accessing services** - Within this review it has been unclear whether those affected by abuse, directly or indirectly, knew about the

services available. We do know neither James nor Dean engaged with specialist domestic abuse provision. Dean's families' perception was the existing services did not resonate as they were not LGBT+ focused.

- **Safeguarding** - There were opportunities for ASC to undertake an assessment of the safeguarding risk for both James and Dean that did not take place. There were missed opportunities to refer into ASC and there were not sufficient systems in place to identify escalation.
- **Previous Offending History -** Despite multiple callouts and a high level of involvement, no police officers involved undertook a check on the Police National Computer (PNC) to ascertain if either party had any form of previous offending history related to domestic abuse. The Panel concluded that knowledge of previous incidents could have helped inform and understand the context of what was taking place in this relationship.
- **Perpetrator's interventions -** Perpetrators can be individuals with very complex needs, including their own histories of abuse or neglect, as was the case for James. Consideration could have been given to referring into specialist treatment programs and /or a referral into Multi Agency Tasking and Coordination (MATAC).
- **Coercive and controlling behaviors -** Agencies lack skills and experience in recognising and responding to coercive control and remain focused on responding to violent incidents rather than recognising patterns of abuse.
- **Family and Friends -** The review has demonstrated the critical importance of supporting families; they hold information about abuse and are well placed, if supported, to offer support and raise concerns. Families need support in their own right to access services.

8.0 Conclusions and lessons identified

8.1 The main conclusions and key lessons arising are as follows:

Dean was subject to significant physical, emotional and sexual abuse and coercive control from the almost the onset of his relationship, this escalated very quickly into high-risk abuse. Agencies failed to recognise and respond appropriately and there were clear missed opportunities to safeguard Dean.

8.2 Risks were not effectively assessed or managed and professional curiosity to support disclosure and safety planning was lacking in all agencies. Events that might have been crucial in initiating risk escalation were missed or were not considered within the risk assessment process. Opportunities through the MARAC process for the GP and other health providers to present Dean's experiences were missed.

Perpetrators of abuse are known to be well versed at manipulating their victims, this often extends beyond the relationship to professionals and systems. James was able to assume control of Dean, his family and many of the professionals he encountered. James utilised similar transferrable tactics to exert and maintain control over Dean as he had used in in previous familial and intimate relationships. Failure to check relevant police records and databases missed the historic intelligence which was key to understanding the risk James posed both to his victim and to professionals.

8.3 There are barriers to reporting abuse (for both victims and family members) and a lack of knowledge and awareness around how to report or where to seek advice, guidance, and support. This is amplified for those with complex needs and the LGBTQ+ community. Dean was pushed into the margins, his experiences of being victimised were largely unheard. Agencies demonstrated a lack of understanding in relation to same-sex abuse and consistently underestimated risk levels.

8.4 Substance misuse masked agencies' ability to gain a greater understanding of the domestic abuse and focus was to a large extent placed on managing risk in relation to alcohol.

8.5 The DHR process was lengthy and protracted, changes in organisational structures and systems have impacted on the Author's ability to ensure review rigour. The CSP acknowledge this and a robust plan is now in place to ensure lesson identified are implemented.

9.0 Recommendations

9.1 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. Dean's family have endorsed support for these recommendations.

9.2 Alongside these specific recommendations the panel also concluded that a review of the commissioning and oversight of DHR's was required to ensure robust processes were in place.

Setting the Strategic Context
The current multi agency arrangements for Domestic Abuse and Safeguarding should be subject to review to establish and ensure that all aspects of these arrangements are fit for purpose and reflect the learning from this review in respect of the following: • Governance • Policy & Procedures • Practice guidance • Thresholds and processes • Notifications and Referrals • MARAC • Information Sharing • DHR processes

Ensure that the Safeguarding Adults Board reflects the importance of tackling alcohol problems when protecting vulnerable people
That the CSP takes leadership across the multi-agency safeguarding partnerships in North Tyneside to assess safeguarding strategies in relation to access to services for LGBTQ+ communities
That CSP acts on the systemic and cultural barriers in place that may lead to LGBTQ+ community not receiving specific support services.
That the CSP ensures LGBTQ+ people's needs are recognised and made clearly visible in local policy/procedure frameworks, strategic/needs assessments, and commissioning frameworks
That the CSP should undertake research on best practice in relation to working with LGBTQ+ communities with specific focus on identification of primary perpetrators
That the CSP collaborates with other LA and considers joint commissioning across a wider Northumbria or North East footprint.
That the CSP acts to raise awareness of available sources of help and support in the LGBTQ+ community and the wider community and specifically for families and friends.

Training
That the CSP commissions LGBTQ+ and domestic abuse awareness raising training and embeds this across the partnerships
All staff working with alcohol and domestic violence are trained in techniques for working with change resistant drinkers for example as set out in the Blue Light manual

Assessment & Risk Assessment
Local commissioners of both domestic abuse and alcohol services must ensure that:
Risk assessments adequately reflect the seriousness and dynamic nature of the risk associated with problem drinking in the context of domestic violence
That immediate consideration should be given to the terms “perpetrator” and “victim” how these concepts are assessed and recorded reflecting on current best practice and research
All agencies to initiate a DASH on receiving a disclosure of abuse
Review of the MARAC arrangements

National
The CSP requests the Home Office to consider initiating a review into the effectiveness of the DASH Risk Indicator Checklists in relation to LGBTQ+ communities.

Criminal Justice
Northumbria Police to ensure Police National Computer (PNC) checks are carried out routinely in respect of all future complex domestic abuse cases – and provide assurance to The Safer North Tyneside Board.
Northumbria Police to ensure DVPO and DVPN are utilised robustly.

Annex 1 Glossary of Terms

A&E	Accident and Emergency
ACPO	Association of Chief Police Officers
APP	[College of Policing's] Authorised Professional Practice
ASC	Adult Social Care
ASBO	Anti-Social Behaviour Order
ATR	Alcohol Treatment Requirement
CCG	Clinical Commissioning Group
CJLDT	Criminal Justice Liaison and Diversion Team
CPS	Crown Prosecution Service
CSP	Community Safety Partnership
DASH	Domestic Abuse, Stalking and Honour Based Violence
DBS	Disclosure and Barring Service
DHR	Domestic Homicide Review
DVO	Domestic Violence Officer
DVPN	*Domestic Violence Protection Notices*
DVPO	Domestic Violence Protection Order
ED	Emergency Department
ESA	Employment and Support Allowance
FACE	Functional Assessment of Care Environment
GP	General Practitioner
IDVA	Independent Domestic Violence Advisor
IMR	Individual Management Review
IOPC	Independent Office of Police Conduct
ISVA	Independent Sexual Violence Advisor
KLOE	Key Lines of Enquiry
LGBTQ	Lesbian, Gay, Bi-sexual, Transgender, Questioning +
LHA	Local Housing Allowance
MARAC	Multi Agency Risk Assessment Conference
MATAC	Multi Agency Tasking and Coordinating
NEAS	North East Ambulance Service
NFA	No Further Action
NHCFT	Northumbria Health Care NHS Foundation Trust
NHSE	National Health Service England
NPT	Neighbourhood Policing Team
NTRP	North Tyneside Recovery Partnership
NTW	Northumberland, Tyne and Wear NHS Foundation Trust
PACE	Police and Criminal Evidence Act
PER	Prisoner Escort Record
PCU	Patient Care Update
PNC	Police National Computer
SAPP	Safeguarding and Public Protection Team
SNTB	Safer North Tyneside Partnership Board
VFN	Victims First Northumbria