SOUTHEND COMMUNITY SAFETY PARTNERSHIP

Domestic Homicide Review The Green Case

Executive Summary

Report Author: Christine Doorly

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Section 1:
The Review Process
1.1 Commissioning the Review:
This review was commissioned by the Chairperson of the Southend Community Safety Partnership. Mr Green killed his grandfather and assaulted his grandmother (referred to as Mr and Mrs Blue) on 14th November 2013. The Southend Community Safety Partnership was notified by Essex Police the following day. The Home Office were notified by the Southend Community Safety Partnership of their decision to undertake a Domestic Homicide Review on January 8th 2014. Mr Green was subsequently convicted of murder and attempted murder for the relevant offences. It was deemed that the threshold for a Domestic Homicide Review was met, and that this was to be undertaken under the auspices of the Southend Community Safety Partnership.

The primary purpose of this review is to determine whether there are any lessons to be learned in terms of how agencies worked together, and to make improvements in services. This review has followed the Home Office Guidance on Domestic Homicide Reviews, as amended in 2013.

Home Office Guidance identifies the following points as the purpose of a Domestic Homicide Review:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

- Apply these lessons to service responses including changes to policies and procedures as appropriate; and

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

In addition, Home Office Guidance states that:

- Domestic homicide reviews are not inquiries into how the victim died or into who is culpable; that is a matter for coroners and criminal courts, respectively, to determine as appropriate.

- Domestic homicide reviews are not specifically part of any disciplinary enquiry or process. Where information emerges in the course of a domestic homicide review indicating that disciplinary action should be initiated, the established agency disciplinary procedures should be undertaken separately to the domestic homicide process. Alternatively, some domestic homicide reviews may be conducted concurrently with (but separate to) disciplinary action.

The rationale for the review process is to ensure agencies are responding appropriately to victims of domestic violence by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future

incidents of domestic homicide and violence.

The review will also assess whether agencies have sufficient and robust procedures and protocols in place, which were understood and adhered to by their staff.

This review has been conducted under Section 9 of the Domestic Violence, Crime and Victims Act 2004, which came into force on 13th April 2011, inter alia:

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

- A person to whom he/she was related or with whom he/she was or had been in an intimate personal relationship;

Or

- A member of the same household as himself/herself

1.2 The Review Panel:
Christine Doorly, an Independent Consultant, was appointed to conduct this review, and to produce the Overview Report.

The review commenced with the appointment of a suitable panel to advise and support the process. The panel consisted of the following agencies and their representatives:

- Southend Borough Council (to include Children and Adult Social Care, Housing Services and the Drug and Alcohol Team)

- Essex Police

- South Essex Partnership University NHS Foundation Trust (SEPT) including Atrium Clinical Services- a joint individual management review was agreed.

- South Essex Homes

- Southend University Hospital NHS Foundation Trust (SUFHT)

- NHS England /Southend CCG

Provision was reserved to co-opt additional experts to the panel if this was felt to be appropriate. However this was not required.

In addition, the following representatives were retained on the panel to support it with professional advice:

- Head of Health Development: Southend Borough Council

- Group Manager Community Safety: Southend Borough Council

1.3 Terms of Reference
This Panel determined the Terms of Reference for the Review as follows:

Were practitioners sensitive to the needs of the victim and perpetrator, knowledgeable about potential indicators of domestic violence, and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

Did the agency have policies and procedures for (DASH) risk assessment and risk management for domestic violence victims or perpetrators and were those assessments correctly used in the case of this victim or perpetrator? Did the agency have policies and procedures in place for dealing with concerns about domestic violence? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC (Multi Agency Risk Assessment Conference)?

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

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

Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments given what was or should have been known at the time?

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

Was anything known about the perpetrator? For example were they being managed under MAPPA (Multi Agency Public Protection Arrangements, which exist to manage the threat to the public from high risk offenders)?

Had the victim disclosed to anyone, and if so, was the response appropriate?

Was this information recorded and shared, where appropriate?

Were procedures sensitive to the ethnic, cultural linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary?

Were senior managers or other agencies and professionals involved at the appropriate points?

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

Are there ways of working effectively that could be passed on to other organisations or individuals?

Are there lessons to be learned from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses

and manages the risks posed by perpetrators? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

How accessible were services to the victim and the perpetrator?

To what degree could the homicide have been accurately and predicted and prevented?

The panel also identified the following issues as of particular concerns in this case, and requested that Individual Management Reviews address these areas:

- Analysis of each agencies involvement with the victim and alleged perpetrator should be undertaken with particular reference to the agencies policies and procedures and the agency context of their involvement.

- When considering the risk (if any) that the alleged perpetrator presented to other partners did the agency consider the potential risk to this victim?

- The impact of any substance misuse by the alleged perpetrator, victim, or other significant persons.

The time line was agreed subject to there being no significant information which would lead to it being reviewed, which did not occur. Therefore it was that, in respect of the victim and perpetrator, all information to be supplied in detail from 8th December 2009.
In respect of all other associated persons, agencies are work from December 8th 2009 in detail, but as above to include any previous information which is potentially relevant.

1.4 Individual Management Reviews
The following Individual Management Reviews were commissioned:

- Southend University Hospital NHS Foundation Trust (SUFHT)

- Essex Police

- South Essex Partnership University NHS Foundation Trust (SEPT) and Atrium Clinical Services; agreed to conduct a joint individual management review but actually produced two separate but liked individual management reviews as their recent affiliation made it too difficult to merge their information. (IAPT is a primary care counselling service of which SEPT is the NHS partner). This was agreed by the chair and the two reports were generally consistent with each other.

- South Essex Homes

- NHS England/ Southend CCG, individual management review produced by the Valkyrie Surgery in respect of Mr Green

- Southend Borough Council; no individual management review was produced as the Local Authority had no involvement which met the terms of reference.

Each of these individual management reviews were undertaken with the instruction to use a range of suitable methods, including staff interviews as appropriate, analysis of

paperwork and case records, and evaluation of the organisation's policy and procedural documentation and other material factors. They made reference to local and national policy where appropriate. There was very little content to any of the individual management review in respect of relevant information and the most significant individual management review in this case was that of SEPT/the IAPT service. All of the individual management reviews were deemed by the Overview Report Writer (and chairperson of the panel), to be of an acceptable standard given the very limited nature of agency contact in this case.

1.5 Information from the Victims Perspective

Information from the family, in particular the victim's perspective, is very important in conducting these reviews. Following a meeting between the Police Senior Investigating Officer and the review chairperson, it was not deemed to be appropriate to interview any family members before completion of the criminal trial. However on completion of the trial it was felt by the review chairperson that the perpetrator should be invited to give an interview in order to try and better understand how he came to commit this action, in order to identify if there are any lessons to be learned. In addition, it was also felt that the possibility of speaking to other family members should also be considered once the trial is over. At the completion of criminal justice processes and on conviction of Mr Green for murder, the chair wrote to him as requested an interview to which there was no response. In the absence of an interview from Mr Green it was not deemed to be appropriate to interview other family members as given the nature of the events which occurred there was no sense in which the victims were the subjects of domestic abuse prior to the attack, or could represent that experience.

Following initial evaluation by the Home Office and on the advice of the panel chair, Mr Green was again contacted and invited to contribute to the Domestic Homicide Review. Although support arrangements were put in place this did not evoke a response and therefore it has not been possible to throw any further light on the motivation for the attack apart from the allegation of historic sexual abuse of Mr Green's sister.

Section 2

2.1 Key Issues in Respect of this Review

The summary of events which led to this review shows that it seems, in 2010, Mr Blue and his wife, the grandparents of Mr Green, who had been living with their daughter for the past 5 years, suddenly felt they could not do so any more, describing the reason as being that this was due to a family dispute. They were rehoused and given a tenancy.

It is believed, on the basis of information which has emerged subsequent to Mr Blues' death that the family dispute referred to was an allegation circulating within the family that Mr Blue had sexually assaulted his granddaughter, Mr Green's sister, when she was a child. However this was denied, by Mrs Blue for example, as being untrue.

Meanwhile Mr Green had no contact with his grandparents during this period. He was living with a long term partner until shortly before the assault occurred. He began attending Atrium for counselling services following a referral by his GP, from July 2013. Here he disclosed suicidal ideation and self-harm. By November of 2013 he disclosed in counselling that he was leaving his long term partner, and he also discussed the alleged abuse of his sister and the idea of communicating with his grandfather about this. His mood was identified as improved at this point. At this point he was working as a window cleaner, he had other job prospects in line, and he had recently moved in with a new partner whom he had befriended during his window cleaning work. He had also apparently

given up his habitual cannabis usage.

It would seem that on the day of the assault, 14th November 2013, he had sought from other family members the contact details and address of his grandparents and arranged to visit them. He did not disclose to anyone any information which would alert them to his posing a threat or a danger. His actions on the morning of the assault were not suspicious and reportedly included getting a tattoo.

He later arrived at their home and proceeded to tie them up and obtained a knife from the kitchen which he used to attack both his grandfather and grandmother, citing the sexual abuse of his sister as a rationale. He was apparently calm and not especially agitated. They were compliant with his actions as they did not initially perceive there to be any threat. He killed his grandfather and injured his grandmother, but she was able to get away and was assisted by a housing officer who was the first person to arrive on the scene. Mr Green immediately admitted the attacks and again cited to police the alleged sexual assault on his sister as his rationale.

Analysis of agency involvement with the family showed there had been no report made about the alleged sexual abuse cited by Mr Green as the rationale for the attack made. The services used by the family, and for the most part by the perpetrator, were largely universal services such as primary care or housing services. Mr Green was referred for counselling to a primary care counselling service provided by Atrium and did disclose some suicidal ideation and thoughts of self-harm. This in itself was not necessarily cause for escalating his care to a secondary tier of mental health services, although the review did highlight that arrangements for counsellors to have systematic access to supervision and clear pathways for onward referral could be improved, and made recommendations for doing so which were accepted by the review panel. However the counsellor in this case made good use of supervision and it is not felt this would have altered the outcome in this case since the assault essentially appeared to come out of the blue.

Although Mr Green disclosed in counselling that he had been involved in a previous incident of domestic abuse in the past, not involving the victim of this review, this incident was not reported to the police at the time and there had therefore never been a formal risk assessment by the police, nor an opportunity for this to be undertaken.

The review found that records at the Valkyrie Surgery which provided Mr Green with primary care were not consistent with the information provided by Atrium, and additionally this individual management review did not assure the panel about the practice's domestic abuse policies and procedures, hence the one overview recommendation that NHS England as the commissioning body for this service should reassure itself that the practice now has these in place.

All the other recommendations contained in the individual management reviews were agreed by the Community Safety Partnership and will be monitored by them, along with the one overview recommendation.

Section 3

3.1 Conclusion and Recommendations

This is a somewhat unusual review in that the homicide did not take place within an on-going or escalating pattern of domestic abuse. The perpetrator had not seen the victim for many years and it will probably never be possible to understand his motivation for the attack, other than his stated rationale. It is therefore also not possible to reflect on the

victim's perspective in terms of improving services or learning lessons from this case. However, every opportunity was taken for the professionals involved to reflect opportunistically on any improvements which could be made, and whilst the majority of these were contained in the individual management review for Atrium, now part of the SEPT, in addition was overview recommendation was made as follows:

That NHS England reviews the policies and procedures of the Valkyrie Surgery in respect of domestic abuse and monitors the implementation of any action plan and recommendations, as appropriate.

It should be made clear that the view of the panel was that none of these areas as reflected in the individual management review or overview recommendations would have been likely to have made any difference in this case, the overview report conclusion being that this homicide was neither predictable nor preventable.