1. **EXECUTIVE SUMMARY**

2. **INTRODUCTION**

3. This Domestic Homicide Review (DHR) examines agency responses and support given to Adult Elizabeth, up to the point of her death.

4. The key purpose for undertaking a DHR is to enable lessons to be learned from homicides, where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned, as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide; and most importantly, what needs to change, in order to reduce the risk of such tragedies happening in the future.

5. **BACKGROUND INFORMATION (THE FACTS)**

6. The circumstances leading up to this DHR being undertaken are detailed as follows:

7. The Safer Sunderland Partnership (SSP) received information from Northumbria Police in February 2020 of a homicide and suicide they had attended in Sunderland in the same month.

8. A summary of the Police notification to the Safer Sunderland Partnership received in February 2020 is detailed as follows:

9. The victim Elizabeth, and her son, the perpetrator, Sean, lived together, in Sunderland.

10. Northumbria Police had recorded a number of domestic violence and abuse incidents by Sean towards Elizabeth from as far back as 1997 to February 2020.

11. Elizabeth was last at work for the local Charity in early February 2020 and was then due to attend work a week later, but she never arrived. The Charity Staff had spoken to Elizabeth by telephone during the week.

12. Concerned Elizabeth had not attended work, over the following days, staff at the Charity made a number of efforts to contact her by telephone, but only ever received an answer from Sean; who claimed his mother was ill. Sean was abusive towards the Charity Staff on the telephone.

13. Neighbours describe hearing, and or seeing, Elizabeth during the period she was absent from work, but cannot be precise when this was. One witness

reported hearing Elizabeth and Sean rowing during the early hours on the morning.

14. A concerned Member of Staff from the Charity called at Elizabeth's home address in late February 2020 but got no answer. On looking through the living room curtains she saw Sean, motionless on the sofa. As a result of this she contacted her office, who, in turn contacted the Police.

15. Upon Police attendance, entry was forced, and Elizabeth and Sean were both found, deceased, within the living room. Elizabeth was on the floor beside the sofa with a number of, what appeared to be, stab wounds. Sean was naked on the sofa, with no obvious injuries.

16. A post-mortem of Elizabeth and Sean took place shortly afterwards. Elizabeth had nine stab wounds, the fatal two being to her jugular.

17. Elizabeth had been dead for some time, up to possibility a week. Elizabeth died due to stab wounds to her neck.

18. Toxicology In relation to Elizabeth showed:

- Blood alcohol 312mg/100ml.
- Nicotine and its metabolite and caffeine detected in blood.
- No other drugs collected.

19. The Ethanol concentration was described as sufficient to impair cognitive and motor functionality.

20. The conclusion was Elizabeth was unlawfully killed.

21. Sean had no injuries consistent with assault.

22. Toxicology in relation to Sean showed:

- Blood codeine 2774 mg/ml.
- Blood free morphine 9 ng/ml.
- Blood total morphine 11 ng/ml.
- Blood paracetamol 537 mg/l.

23. The blood Paracetamol level was described as grossly elevated and within the quoted lethal range. The blood Codeine level was described as within the quoted lethal range. Some Codeine is converted in the body into

Morphine. There were no other identifiable drugs. The vitreous biochemistry results were unremarkable.

24. The conclusion was Sean died as a result of a Codeine overdose.

25. **HM CORONER**

26. An inquest into the deaths of both Elizabeth and Sean was held by HM Coroner in March 2020.

27. The Assistant Coroner described the relationship between the mother and son as ‘problematic’, adding, the son was ‘very controlling’ and was both emotionally, and sometimes physically, abusive.

28. The Assistant Coroner continued ‘It seems clear she (Elizabeth) was a very independent, proud mother but that, effectively, this has ultimately led to her death because she obviously had difficulties with Sean.’

29. She said Elizabeth’s ‘mother's instinct’ must have made it ‘doubly difficult to effectively walk away from the situation’.

30. The conclusion was Elizabeth was unlawfully killed.

31. The Coroner arrived at the conclusion Sean died as a result of a Codeine overdose.

32. HM Coroners enquires are now complete.

33. **TERMS OF REFERENCE**

34. The Terms of Reference for this DHR are detailed as follows:

35. **1. To consider the impact of decisions made in relation to Elizabeth on her overall wellbeing; and whether any potential impact was recognised and whether she was supported.**

36. **2. To consider Elizabeth’s death in light of national/local suicide prevention strategies. What were the quality of risk assessments and risk management plans in response to known incidents?**

37. **3. To consider whether any risks were identified assessed at the appropriate level?**

38. **4. To consider whether the MARAC process implemented in line with local policy and procedures? (Please include appropriate policies and procedures).**

39. **5. To consider whether there is any evidence Elizabeth and Sean were offered assistance to address alcohol related issues, and if they were, what were the outcomes?**

40. **6. What were the quality of risk assessments and risk management plans in response to known incidents? Were the risks to Elizabeth appropriately assessed at the correct level of risk? Were static factors present in all risk assessments?**

41. **7. If so, for Elizabeth, did this result in appropriate needs assessment and safety planning actions and what was the evidence of this?**

42. **8. If the process was not implemented in line with local policy, procedure, and guidance, what were the reasons for this?**

43. **9. Were there any missed opportunities for routine or selective enquiry about domestic abuse where agencies knew Elizabeth was experiencing domestic abuse?**

44. **10. Was appropriate use made of available civil and statutory tools and powers: including but not limited to Civil Orders, Domestic Violence Protection Notices (DVPNs), Domestic Violence Protection Orders (DVPOs), Domestic Violence Disclosure Scheme (Clare's Law) etc?**

45. **11. Where services and protection planning could not be delivered due to non-engagement of Elizabeth, were the reasons for non-engagement explored and what efforts were made to encourage engagement?**

46. **12. Were the correct referral pathways (including but not limited to MARAC) implemented in line with local policy, procedure, and guidance?**

47. **13. How effective was Inter-Agency working and interagency information sharing around addressing the risks that Sean posed to Elizabeth?**

48. **14. Did Elizabeth's' workplace have any cause for concern that Elizabeth may be at risk from domestic abuse by her son?**

- **If so, did this result in any routine or selective enquiry, safety planning and/or risk management actions and what was the evidence of this?**
- **If not, what were the reasons for this?**
- **Did 'Elizabeth's' workplace have a domestic abuse workplace policy? If so, how were staff made aware of these policies.**

49. **15. Subject to Family, Friends, Neighbours, and Work Colleagues of Elizabeth wanting to participate in the review, did they have any cause for concern that Elizabeth may be at risk from domestic abuse by her son? If so, were they aware of support services and how to seek advice and support?**

50. **SCOPE**

51. The timeframe of this DHR is from 14th September 2016 until when the murder / suicide was reported to Police.

52. There is an extensive history between Elizabeth and Sean, with Police records dating back to 1997.

53. The incidents recorded by Northumbria Police between 1997 and 2015 which are out of scope are detailed further in this DHR. Whilst the history has been taken into account, the partnership felt it was disproportionate to examine events over such a protracted period of time.

54. 2016 is significant as this was when a MARAC meeting took place where Elizabeth and Sean were subject of professional discussion.

55. Whilst recognising the long history of violence and abuse between Elizabeth and Sean, this timeframe was considered to be a proportionate period of time for review.

56. **CONCLUSION**

57. It is clear Elizabeth had a difficult life. She suffered the loss of her husband at a relatively young age and was left to bring Sean up alone.

58. Sean presented challenges to his mother from a young age. Over many years he was violent and abusive towards Elizabeth.

59. It would appear over time Sean's mental health deteriorated, and his misuse of alcohol increased, resulting in extreme violence and abusive behaviour in turn causing his mother significant distress and harm.

60. It would appear Elizabeth's health and well-being deteriorated, and she became increasingly isolated from family and friends. Elizabeth appeared to use alcohol as a coping mechanism.

61. The presentation is dichotomous at all levels; Elizabeth presented as fearful but protective of Sean, at risk and at times posing a risk to herself and others through alcohol misuse, help seeking but declining help for herself in the pursuance of help for her son; which may have engaged her in an effective support plan and managed the risk.

62. Elizabeth's and Sean's contact with Agencies and Professionals was inconsistent over time.

63. There is some evidence of Elizabeth engaging with Agencies on occasions when in need but then consistently choosing not to disclose anything, electing not to co-operate or support any further action.

64. There were some missed opportunities from Agencies involved with Elizabeth to utilise a higher degree of professional curiosity to help enquire about, challenge and elicit pertinent information to identify underlying risk issues she may have been experiencing in terms of domestic abuse. In most interactions with Elizabeth, Professionals focused their efforts on her presenting need, and further enquiry could have been undertaken to consider possible indicators of abuse and the interplay between multiple presenting factors (e.g., injuries, depression and anxiety, alcohol use etc).

65. With a small number of exceptions, the presenting information appears to have been accepted at face value by Professionals without any evidence of them trying to clarify, or confirm, if said action had taken place.

66. As a consequence, there were missed opportunities to signpost Elizabeth (and Sean) to relevant Support Services.

67. It is clear a number of Agencies did not have a full awareness, or understanding, of the inter-family violence taking place between Elizabeth and Sean.

68. The escalation of risk was not consistently identified by Agencies. As a consequence, information was not always shared and the opportunity for multi-agency working was not optimised.

69. Professionals, even when acting as part of a joint team, need to be aware of the necessity to make appropriate referrals to allow consideration of further actions and notifications to be made to other parties.

70. The importance of Agencies communicating internally and with each other, ensuring they 'join the dots' and make multi-agency decisions on the most accurate, timely and complete information, cannot be overstated.

71. Had the concerns been viewed holistically there was information, either known or available, which should have given rise to a view significant harm was at least likely.

72. A better understanding of the circumstances which Elizabeth and Sean were living in may have prompted Agencies to adopt a more coherent response.

73. In undertaking this review there were some examples of good practice including the IDVA referring the case to MARAC and the victim follow up WWiN. Further, Northumbria Police attended all of the reported incidents during the scoping period and one occasion submitted a DASH risk assessment. On another occasion, they submitted an Adult Concern Notification.

74. However, whilst taking into account the complex circumstances and the lack of engagement by Elizabeth, I would suggest professional practice was on a number of occasions reactive, rather than a proactive holistic response to the risks presented by Sean towards Elizabeth.

75. It could be viewed Elizabeth was effectively left to manage Sean on her own, when, due to her own vulnerabilities, she was not in a position to do so.

76. This DHR has identified a range of learning opportunities for Agencies and Professionals in supporting vulnerable people who are subject of adult family violence.

77. The learning includes recognising domestic abuse involving a mother and son, the importance of multi-agency working, information sharing, professional curiosity, risk assessments, and the signposting specialist alcohol and drug support.

78. There are a number of strategic considerations which the Partnership are invited to consider:

- Do services or procedures need to be more focussed on engagement with people?

- Are there discussions with people, about the outcomes they want, embedded in key processes at the beginning, middle and end of the process, so the service and procedures drive engagement with people?

- How are Agencies addressing workforce development issues required to ensure people are skilled, and competent, in having difficult conversations with individuals at risk of harm or abuse?

- Are Professionals equipped to work with families, and networks, to negotiate outcomes and seek resolution?

- Do professionals have skills, knowledge, and permission to use the full range of legal and social work interventions needed?

79. A DHR triggered by a murder is by nature a reactive activity.

80. A standard question to consider as part of any DHR is whether or not the person's death could have been avoided had Agencies done more.

81. Whilst the review acknowledges there are some examples of good practice, it has also highlighted there were some missed opportunities to support and safeguard Elizabeth. That is not to say, the murder would have been prevented, but more professional curiosity, better information sharing, and enhanced multi-agency working may have helped to reduce the risk.

82. The murder of Elizabeth by her own son is a real tragedy for the family. There are lessons to be learned from these sad events. These lessons which may help avoid similar distress for others in the future.

83. The findings of this DHR provides an opportunity for Agencies individually, and collectively, to consider their response in light of the learning and recommendations, in order to make the future safer for others.

84. A critique of DHR's over time will identify, despite the commitment of Agencies and Professionals to safeguard the most vulnerable, much of the learning in this review are repeated themes.

85. Creating transformational and sustainable change is a significant challenge for Community Safety Partnerships. The relevant learning and recommendations from this DHR should be disseminated and monitored to support this change.

86. **LESSONS TO BE LEARNED**

87. **RECOMMENDATIONS / LEARNING**

88. **Learning Recommendation 1**

89. **Where a victim elects not to support a prosecution Northumbria Police should specifically record how and why the victim was feeling at the time, whether the decision not to support the prosecution was influenced by fear of the perpetrator and / or for other reasons together with any protective support offered to the victim.**

90. **Learning Recommendation 2**

91. **Professionals within the MASH should ensure sufficient weight is placed on any history between the victim and perpetrator of domestic abuse, together with the account provided by the attending Police officers when undertaking the screening – triage process. This will ensure all of the potential risks have been considered before closing a case with no further action.**

92. **Recommendation / Learning 3**

All Agencies should recognise the importance of Multi-Agency working and follow agreed protocols around information sharing in order to assess and inform risk.

93. **Recommendation / Learning 4**

94. **All Agencies to disseminate to Professionals the Standing Together Against Domestic Violence (Sharp-Jeffs and Kelly, 2016) guidance, as part of their professional development strategies.**

95. **Recommendation / Learning 5**

96. **All Agencies should continue to build upon the training to date and support Professionals around identifying and supporting victims who may be subject of coercive control.**

97. **Recommendation / Learning 6**

98. **The Safer Sunderland Partnership should ensure an all age multi-agency suicide prevention plan is in place. Agencies should ensure training and guidance is provided to Professionals around preventing suicide.**

99. **Recommendation / Learning 7**

100. **All, All Professionals, who are likely to come into contact with victims and perpetrators, should be trained in carrying out risk identification and assessment.**

101. **Recommendation / Learning 8**

102. **All Agencies should consider routinely submitting a DASH and / or an ACN risk assessment where domestic violence or abuse be identified or suspected, including inter-family violence.**

103. **Recommendation / Learning 9**

104. **MASH Professionals should ensure the history between victim and perpetrator are fully considered in assessing risk and making a referral.**

105. **Recommendation / Learning 10**

106. **Northumbria Police Neighbourhood Policing Teams should give further consideration to conducting further in-depth research in order to understand the victim and perpetrator, and their complex issues and consider a problem-solving approach in complex cases such as this.**

107. **Recommendation / Learning 11**

108. **Where a number of incidents are reported within a short time frame, Northumbria Police and Partner Agencies should ensure any review process specifically examines whether risk is escalating, and interventions are required.**

109. **Recommendation / Learning 12**

110. **All Agencies should give consideration to reviewing MARAC cases where the victim has disengaged, or never engaged, where there is potential for escalating risk.**

111. **Recommendation / Learning 13**

112. **The Safer Sunderland Partnership should give consideration to the MARAC demand and the capacity of agencies to manage high risk domestic abuse referrals.**

113. **Recommendation / Learning 14**

114. **ICB should ensure that any referral to MARAC should be followed up with further exploration of the issues and the offer of safeguarding support for the victim of domestic abuse.**

115. **Recommendation / Learning 15**

116. **ICB should ensure that any frequent attendance at A&E for a similar complaint should be treated as a 'red flag' inviting further exploration and engagement with other agencies around potential domestic abuse.**

117. **Recommendation / Learning 16**

118. **STSFT and ICB should routinely use professional curiosity where a person frequently presents with injury that may have been as a result of domestic violence or abuse.**

119. **Recommendation / Learning 17**

120. **All Agencies should give consideration to building upon the training to date and improve awareness and understand around the importance of Multi-Agency information sharing in order to promote co-working pathways and holistic responses to domestic abuse.**

121. **Recommendation / Learning 18**

122. **As part of the ongoing campaign to support victims of domestic abuse, the Safer Sunderland Partnership should specifically raise awareness about the importance of third-party reporting.**