

15/01/2014 FINAL EXECUTIVE SUMMARY



**DOMESTIC HOMICIDE REVIEW:
INDEPENDENT OVERVIEW REPORT
INTO THE DEATH OF
"GUSTAS"**

EXECUTIVE SUMMARY

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1) THE DOMESTIC HOMICIDE REVIEW PROCESS:

1.1 Who the report is about:

This report of a domestic homicide review examines agency responses and support given to “**Gustas**”¹, a resident of North Tyneside prior to his death in spring 2013. He was in his early 20s when he died.

The review considers agencies’ contacts and involvement with Gustas and his nephew “**Lukas**” who was 18 when the incident took place.

Later in 2013 Lukas was convicted of manslaughter and an eight year prison sentence was imposed.

1.2 Purpose of the review:

The key purpose for undertaking Domestic Homicide Reviews (DHR) is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence. 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.

1.3 Confidentiality:

Home Office guidance makes it clear that this report **must be treated as strictly confidential and should not be circulated, other than to members of the DHR Panel and their line managers**. Once Safer North Tyneside has signed off the overview report and executive summary, these will be forwarded to the Home Office Quality Assurance Group, together with supporting documents.

2) OVERVIEW OF EVENTS AND MULTI-AGENCY RESPONSES:

¹Pseudonyms (of eastern European origin to reflect the nationality of the family) are used throughout the report to help maintain confidentiality of the victim and family members

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2.1 Gustas

Gustas was a recent immigrant from eastern Europe and was in his early 20's. Almost nothing is known about his background, prior to arrival in the UK. Most of his friends and associates were also young eastern European men. He had reasonable ability to speak and understand English, but struggled with official forms and terminology. His closest known relative was his sister (mother of the perpetrator), who died of cancer just a few weeks before he was killed by Lukas.

All of the evidence seen by the DHR suggests he was an extremely vulnerable young man, presenting with a complex and challenging set of needs and behaviors. He was not an easy person to help. He consumed such large volumes of alcohol that he was frequently incapable of looking after himself or protecting himself from others, who may take advantage of him. He had a life threatening medical condition, but was often incapable, unwilling (or both) to comply with medication. He lived in an insecure squat, frequented by groups of young men, who probably also misused alcohol and other substances. On occasions he told professionals trying to help him that he had been threatened with violence, including an attempted stabbing. There were also reports of alleged financial abuse. He made a serious attempt at suicide, causing severe lacerations to his arms and losing an estimated four pints of blood. On another occasion he was rescued from the River Tyne. It is not known whether this was an alcohol related accident, a suicide attempt, or a malicious act by others.

In summary, there was clear evidence that Gustas was a very vulnerable individual who was at risk of harm, even if the available information did not suggest domestic violence as a specific or significant risk factor. Large elements of this risk were from self-harm and self-neglect, but there was also evidence that he was at risk of significant harm from others.

2.2 Domestic homicide

This was a domestic homicide, by virtue of the fact that Gustas was killed by his nephew. However, the evidence reviewed by the DHR does not suggest that any of the

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services had prior access to information indicating that he was at risk from violent behaviour by Lukas, or any other family member . There had been some relatively minor incidents resulting in criminal justice interventions with the perpetrator, including one where Gustas was the victim of a reported theft.

On the other hand, there was significant evidence to suggest a risk of violence (and other forms of abuse) from his “friends” and associates, one of whom happened to be Lukas. In this context the fact of it being a *domestic* homicide could be seen as incidental, because there was no advance evidence that Lukas presented any particular risk.

The homicide took place just a few days following the funeral of the Gustas’s sister who was also Lukas’s mother. It is very probable that the emotional trauma of her death was a major contributory factor to the homicide. This would have been a uniquely upsetting period for both the perpetrator and the victim, but it would have been impossible for any of the agencies involved to predict such a tragic outcome.

As none of the agencies could have reasonably predicted a significant risk of domestic violence, it follows that there were no specific actions which any of them could have been expected to take, which could have prevented this homicide.

2.3 The challenges of working with a vulnerable adult with severe alcohol dependency and a chaotic lifestyle:

There was clear evidence that Gustas was a very vulnerable individual who was at risk of harm, even if the available information did not suggest domestic violence as a specific or significant risk factor. Large elements of this risk were from self-harm and self-neglect, but there was also evidence that he was at risk of significant harm from others. His addiction to alcohol was a central factor in all of these risks. Any single or multi agency risk reduction strategies were very likely to be undermined by his own behaviour, unless he could bring his alcohol use under control. At the risk of understatement, protecting this young man from his own behaviour and that of people

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around him would have presented an enormous challenge for any combination of health, social care, criminal justice, housing and welfare benefit services.

2.4 Weaknesses in single and multi-agency responses

Having recognised the major challenges presented by this young man, it is also important to highlight the fact that there were some weaknesses in agencies' interventions. None of these weaknesses directly contributed to the homicide taking place. However it can be argued that they contributed to the already well established pattern of chaos and instability in his life and missed opportunities to assess needs and risks. Examples include:

- Inefficient processing of benefits claims, resulting in long periods with no income, followed by sudden large payments to a person with chronic substance dependency problems.
- Problems of communication between youth and adult justice systems, resulting in the Youth Offending Service (YOS) having incomplete information about the perpetrator's alcohol use and associated risks.
- Housing needs not being addressed, partly due to problems with benefits claims.
- Specialist housing support service refused due to health to risks staff, without a robust risk assessment based on advice from professionals with relevant knowledge and expertise.
- Lack of clarity on interpretations of the categories locally agreed between the three authorities North of Tyne and Northumbria Police to guide the Central Referral Unit when making safeguarding referrals.
- Lack of clarity about Fair Access to Care, resulting in missed opportunities for assessment of social care needs.
- Lack of awareness and implementation of NICE guidelines on the housing needs of people with complex needs who have multi-drug resistant TB.
- Shortage of local services which are suitably skilled and resourced to work effectively with people who have chronic substance dependencies and complex needs

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It must be emphasised that none of the above weaknesses had a direct causal relationship with the fact of the homicide incident itself. However, it is reasonable to observe that any possibility (however small it may have been) of Gustas starting to take some control of his life – and in particular of his alcohol consumption – would have been increased if these weaknesses had not been present. If he had been able to bring his alcohol consumption under control, it is reasonable to believe that he may then have been in a position recognise and more effectively manage the other risk factors in his life.

3) KEY LEARNING

This section of the report summarises key learning points, responding to the questions set out in Terms of Reference:

3.1 If there was a low level of contact with any services agencies why was this so?

Most agencies had very little (if any) contact with the perpetrator, but this was because there was no apparent reason to suggest contact would have been appropriate. There was contact with criminal justice services (Police, YOS, courts).

Gustas had high levels of contact with a range of NHS services. He also had contact with adult social services, housing and statutory homelessness services, police and others. However, he was denied help from a specialist support service (floating support) for people with housing related needs, despite a referral being made for this service. It is understood that this was due to information contained in the referral, indicating that he presented a potential risk of TB infection to staff. However, the decision to deny this service appears to have been taken by the provider, without having sought any specialist advice on whether or not there was a significant risk, or on how any such risks could be effectively managed. This is despite the provider having the contact details of the TB community nursing service which was in daily contact with Gustas.

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Gustas was also unable to access stable or secure accommodation, primarily as result of ongoing problems with his benefits claims. A related learning point is that there are specific NICE guidelines about housing people with drug resistant TB, who may not be entitled to benefits, but the evidence seen by the DHR indicates that local agencies were unaware of these guidelines.

3.2 Were there any barriers (particularly ethnic origin, culture or language) to either the victim or the accused accessing services and seeking support?

Both victim and perpetrator appear to have had a reasonable ability speak and understand basic English. The perpetrator was supported by the YOS to access English as a Second Language course. Also, Northumbria Healthcare NHS Foundation Trust arranged an interpreter for Gustas. These are noted as examples of good practice.

Gustas had some difficulty with official language, forms and formal correspondence. Despite possible language issues, he was able to access a range of health care services and ask for advice and support with housing and welfare benefits issues. The Adult Social Care Individual Management Report (IMR) has noted that he was not offered an interpretation service, even though it was known that he struggled with official language and forms. It seems probable that language issues did impair Gustas's ability to effectively navigate services, though the available evidence does not indicate that language was a significant barrier to seeking help for immediate and urgent needs. As a recent immigrant, there were barriers other than language, which meant that support and services were less easily accessible, as proved to be the case with his benefits claims. The DHR panel has also noted that stigma resulting from his immigrant status and TB diagnosis is likely to have been a significant issue.

An additional factor is that attitudes towards police and other institutions of authority are likely to differ between different immigrant populations. For example, one IMR recorded a comment to the effect of "*where I come from you don't call the police*". Certainly, it is

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important for services to be aware that some immigrant populations may have had very negative experiences of police and other public authorities in their country of origin, resulting in low levels of trust. On the other hand, it should be acknowledged that there are sections of the indigenous UK population which could equally subscribe to the “*where I come from*” quote.

3.3 Was there indication of the victim being isolated by the accused and could this have prevented them from contacting services?

The DHR has seen no evidence of Gustas being isolated by the perpetrator, or by anybody else.

3.4 Were there any other issues relating to this case such as drug or alcohol abuse and if so what support was provided (victim and accused)?

Clearly, alcohol was a central factor in this homicide, as the victim suffered from severe alcohol dependency. Additionally, both victim and perpetrator are believed to have been heavily under the influence of alcohol when the homicide took place.

Prior to the offence, there was only limited evidence to suggest that the perpetrator’s use of alcohol was problematic, though there had been some incidents of relatively low level crime and aggressive behaviour when he had been drinking. He had not been offered any specialist support or treatment for alcohol problems. However, there had only been a very short period of contact with criminal justice agencies and alcohol awareness work was an element of planned YOS interventions. On the basis of the evidence available prior to the homicide, there would have been no obvious need to consider referral for specialist support.

On the other hand, the homicide victim had a severe and long term alcohol dependency problem, which was a key element of multiple risk factors in his life. He was provided with support for this problem, through referrals (by his GP and hospital based TB treatment provider) to the NHS addictions service at Plummer Court. Additionally, the

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community TB nurses went to considerable lengths to support and encourage him to engage with treatment at Plummer Court. This is noted as good practice. He made some very limited progress with his treatment programme, but quickly relapsed and was discharged from treatment following several missed appointments.

A key learning point from this case is that there is an unmet need for community based services for chaotic people with addictions and complex needs. Such services need to be sufficiently resourced and skilled to work assertively with people who are not ready to engage effectively with structured treatment programmes.

3.5 Whether the accused had a history of any violent behaviour and if any referrals were made to services in light of this.

The perpetrator had a very recent history of criminal behaviour, some of which included low level incidents of aggression or disruptive behaviour whilst under the influence of alcohol. Following a police warning, he was referred by the police to the YOS, in line with local policy and procedure aimed at diverting young people away from the criminal justice system . The DHR has found that this was an appropriate response, based on all of the information available at that time. It is also noted that the information available was extremely limited, due to the fact that the perpetrator was a recent immigrant . For example, there was no information about his educational background, or whether or not there was any history of offending before he arrived in the UK.

3.6 Whether any risk assessments had been undertaken previously on the victim or accused and whether these had judged risk appropriately.

YOS carried out a risk assessment with the perpetrator, which considered risks of re-offending, harm to others and self-harm. It concluded that the static risk factors were low. The assessment was carried out in line with national standards and guidelines. However the YOS IMR points out that the perpetrator's parents were not consulted as part of this assessment and confirms that this would have been recognised as best practice with a young person who was just under 18 years old at the time of

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assessment. Having said this, it is noted that Lukas's mother was at the latter stages of a terminal illness at this point and the nature of the relationship with his step-father was not clear. Therefore it seems unlikely that parental involvement in the assessment would have significantly changed the assessment findings. Based on all of the evidence available at that time, it appears that risk was judged appropriately.

A Northumbria Police assessment in January 2013 concluded that Gustas was at medium risk as a repeat crime victim, on the basis that he was a vulnerable alcoholic and it was believed that local people of no fixed abode were attending his address and taking advantage of him. He was not assessed in relation to potential risk of domestic abuse, by the police or by any other agency. As discussed in the agency analysis for Adult Social Care (ASC), there were a number of missed opportunities where needs and risks could have been assessed, either through the community care assessment process, or within formal safeguarding procedures. The evidence seen by the DHR suggests that such assessments would almost certainly not have uncovered any specific domestic violence risks, but they could have more clearly identified general concerns about vulnerabilities associated with his alcohol dependency, chaotic lifestyle and other factors.

3.7 Whether the victim was experiencing coercive control on the part of the accused

There is no evidence to suggest any history of coercive control by the perpetrator of the homicide. There is some evidence that coercive control may have been a factor in some other relationships. For example, Gustas informed a homelessness officer that he had been forced to purchase drugs, under threats of violence. The person he identified as responsible for this behaviour was not the homicide perpetrator.

3.8 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?

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The DHR has seen no evidence that there was an indication of domestic violence or coercive control by the perpetrator against the victim.

3.9 Was there any information offered by informal networks?

Gustas's informal networks appear to have been mainly other young eastern European young men who were also involved in chaotic behaviour, heavy drinking and other substance misuse. On one occasion, a female friend raised concerns with hospital staff about possible financial abuse by people who frequented his flat. This was passed on as an ASC referral, but was not actively followed up as a safeguarding issue.

3.10 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?

There were no children or young people (apart from the perpetrator) involved in this case. The housing department were involved with the wider family, who were given additional priority for council housing as a result of the victim's sister's terminal condition. However, this involvement was purely to assess and meet housing need and did not identify any issues of risk of domestic violence.

3.11 Did the victims, origin, culture or language impact on access to services or service delivery?

Gustas's status as a recent immigrant impacted very directly on access to benefits, as detailed (in section 3.5 of the full report) on the involvement of Department of Work and Pensions (DWP). Systems weaknesses at DWP meant that he spent long periods with no income, followed by sudden influxes of money when back dated claims were processed. This was a significant factor which contributed to his vulnerability.

4) LOCAL AGENCY RESPONSES TO KEY LEARNING

As a result of the key learning identified above, the agencies involved in the DHR process are already implementing a range of actions. Most of these are aimed at

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improving local practice and are not specifically targeted at addressing domestic violence issues. For these reasons, they are not they are not presented as formal recommendations for inclusion in the DHR Action Plan.

Key examples of local agency learning from this DHR are summarised below:

Youth Offending Service

- In all cases where English is a second language, an interpreter must be present for the first interview.
- To have a joint decision making procedure in place that clearly evidences the decision where victim consultation is deemed “not appropriate”
- All 18 year olds are screened prior to sentence to identify current YOS involvement
- All YOS case managers to undertake an advanced diversity awareness programme to reflect the emerging ethnic composition of North Tyneside

Northumbria Police

- Frontline officers to be made aware of the criteria regarding referring vulnerable adults

North Tyneside Council: Adult Social Care

- There is a need for a shared understanding of when safeguarding alerts should be raised by the Police to ensure ASC receive all appropriate referrals.
- There is a need to educate all ASC staff to understand our local commitment and legal responsibility toward adults with drug and alcohol difficulties.
- ASC staff must improve their knowledge and understanding of the issues facing those with problem drug and alcohol use.
- ASC staff must improve their knowledge and understanding of TB.
- Current service options in North Tyneside for those suffering from drug and alcohol dependency are limited and inflexible.
- Some adults at risk are hard to engage and/or fall between the stools of service criteria. North Tyneside needs to develop a new, multi-agency offer to support this cohort to the best of our ability.

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Department of Work and Pensions

- Developing better information to explain criteria and processes for assessing right to reside and habitual residency of benefit claimants.
- Appointing Advisors who will deal specifically with customers who have multiple disadvantages and chaotic lifestyles

North Tyneside Council: Housing and homelessness services

- Housing Advice Officers be reminded of the criteria for submitting adult safeguarding alerts, and further training to be offered if required.

North Tyneside Housing and adult social care services

- There is a need for the Gateway Team (ASC) and North Tyneside Housing, with support from commissioners and NHS specialist services, to consider local training needs in relation to risk assessment and risk management approaches with service users who have infectious conditions. This should include reference to NICE guidance for working with TB patients who may be homeless.

Northumbria Healthcare NHS Foundation Trust

- Patients with alcohol abuse, chaotic lifestyles and associated risk factors such as homelessness to be highlighted as a vulnerability risk factor within safeguarding training on Trust policy

5) RECOMMENDATIONS AND DHR ACTION PLAN

The following recommendations are proposed for formal oversight and review by Safer North Tyneside. They form the basis for the action plan (Appendix 1) which sets out specific actions, responsibilities, milestones, target dates and desired outcomes.

Agency making recommendation	Recommendation
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Youth Offending & Prevention Service	Review of the current PENY notification system to include those turned 18 and under the supervision of the YOS
Northumbria Police	Frontline officers to be made aware of the criteria regarding referring vulnerable adults
Adult Social Care	Together with colleagues in Northumbria Police and Newcastle and Northumberland Council, review the current threshold / criteria for raising alerts.
Adult Social Care	Public Health, together with commissioning colleagues in health and ASC will develop a joint strategy aimed at improving access to a range of services for people with alcohol dependency and chaotic lifestyles, who may not be ready to engage with formal recovery treatment programmes.
Adult Social Care	A suitable forum should be established for assessing and supporting vulnerable adults who choose not to engage or fall outside criteria for mainstream services.
Department of Work & Pensions	DWP to develop protocols to improve liaison / multi agency work with other agencies to ensure those with complex needs are effectively supported
Overview Author	Safer North Tyneside to consider commissioning multi agency training on domestic abuse involving adults with complex needs ² , drawing on the findings from the IMR and the recent Home Office publication “DHRs Common Themes Identified and Lessons Learned” ³

² A recommended training pack / e learning guide on working with adults with complex needs who are vulnerable to abuse is published by **Against Violence and Abuse**: <http://tinyurl.com/noa4j3t>

³ “Domestic Homicide Reviews – Common Themes Identified as Lessons to be Learned, Home Office, Nov. 2013. www.gov.uk/government/publications/domestic-homicide-review-lessons-learned



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Action Plan

Recommendation	Scope of Recommendation	Action to Take	Lead Agency	Key Milestones achieved in enacting the recommendation	Target Date	Date of Completion and Outcome
Youth Offending and Prevention Service						
Review of the current PENY notification system to include those turned 18 and under the supervision of the Youth Offending Service (YOS)	Northumbria wide	To request an analysis of the current number of 18 year olds supervised by the six Northumbria Youth Offending Services to ascertain the scope of the potential impact.	YOS	Understanding of the scale of the impact of not receiving information via PENY for those aged 18 supervised by the YOS	April 2014	Analysis took place on the 6 February 2014. The outcome identified that the six Northumbria YOS were managing approximately 25 18 year olds.
		Following the above action, to request a meeting with all six Youth Offending Services with a representative from		To open the discussion with Northumbria Police as to the opportunities to consider amendments to the current PENY operating process.	May 2014	The meeting with the Northumbria YOS took place on the 6 February 2014 and had a representative from Northumbria Police present. Discussion took place

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Recommendation	Scope of Recommendation	Action to Take	Lead Agency	Key Milestones achieved in enacting the recommendation	Target Date	Date of Completion and Outcome
		Northumbria Police				regarding the necessity to request a Police ICT response to the feasibility of changing the current criteria. Ongoing.
Northumbria Police						
Frontline officers to be made aware of the criteria regarding referring vulnerable adults		Continue training already in place, reiterate referral criteria. Signpost to Instructional Information Systems (IIS).	Northumbria Police		April 2014	A rolling programme of training continues to update police officers (including front line) and support staff regarding the unique issues surrounding incidents involving vulnerable adults. An auditable computer record is in place which enables the dispatch, review and tracking of reported incidents including the referral process to Adult Safeguarding. All front line officers have access (via the intranet) to the Instructional

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Recommendation	Scope of Recommendation	Action to Take	Lead Agency	Key Milestones achieved in enacting the recommendation	Target Date	Date of Completion and Outcome
						Information System (IIS) which details the referral criteria for vulnerable adults.
Safer North Tyneside – Community Safety Partnership						
Safer North Tyneside to consider commissioning multi agency training on domestic abuse involving adults with complex needs ⁴ , drawing on the findings from the IMR and the recent Home Office publication “DHRs Common Themes Identified and Lessons Learned” ⁵	Local	Domestic Abuse (DA) Coordinator to review domestic abuse training to: <ul style="list-style-type: none"> • Be aware of recommendations from National and Local DHR’s; • Clarify the links between Domestic Abuse (DA) and complex needs 	Children, Young People and Learning	Adult Social Care (ASC) training scheduled Local Safeguarding Children Board (LSCB) training scheduled	June, 2014 October 2014 February 2015 May, 2014 July, 2014 November	ASC 1 day DA course reviewed by DA Coordinator and ASC trainer to include learning from DHR’s nationally and locally. Updated course for ASC timetabled for 3 times a year, first session 12 th June 2014. LSCB 1 day DA course updated as above, and timetabled for 4 times a year.

⁴ A recommended training pack / e learning guide on working with adults with complex needs who are vulnerable to abuse is published by **Against Violence and Abuse**: <http://tinyurl.com/noa4j3t>

⁵ “Domestic Homicide Reviews – Common Themes Identified as Lessons to be Learned, Home Office, Nov. 2013. www.gov.uk/government/publications/domestic-homicide-review-lessons-learned

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Recommendation	Scope of Recommendation	Action to Take	Lead Agency	Key Milestones achieved in enacting the recommendation	Target Date	Date of Completion and Outcome
		(including Mental health, Dementia and Substance misuse).			2014 March, 2015	
North Tyneside Council – Adult Social Care						
Together with colleagues in Northumbria Police and Newcastle and Northumberland Council's review the current threshold/criteria for raising alerts.	North of Tyne region.	Meet with colleagues to review the current criteria and work through cases studies to test shared understanding of implementation.	North Tyneside Council – Adult Social Care	Meeting held. Mutual understanding of what constitutes a suitable safeguarding referral.	April 2014	Safeguarding leads for North Tyneside and Newcastle met with the Central Review Unit of Northumbria Police on 10 February 2014. The criteria was reviewed and revised in March 2014.
Public Health, together with commissioning colleagues in health and Adult Social Care will develop a joint strategy aimed at improving access to a range of services for people	North Tyneside	Agree a joint strategy for alcohol services with health, public health and Adult Social Care to maximise resources and expertise.	North Tyneside Council – Public Health	Joint strategy agreed. Increased variety of service options. Improved treatment completion rates. Reduced alcohol	April 2014 Sept 2015 April 2015 April	The Alcohol Strategy has been developed, which includes provision for people with complex needs. The Strategy is out for consultation which ends the 4 August 2014. A key action of the

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Recommendation	Scope of Recommendation	Action to Take	Lead Agency	Key Milestones achieved in enacting the recommendation	Target Date	Date of Completion and Outcome
with alcohol dependency and chaotic lifestyles, which may not be ready to engage with formal recovery treatment programmes.				related hospital admissions.	2015	strategy was to review and procure Specialist Drug and Alcohol Treatment, this was commissioned from 1 April 2014
A suitable forum should be established for assessing and supporting vulnerable adults who choose not to engage or fall outside criteria for mainstream services.	North Tyneside	Collaborate with statutory agencies to form, evaluate and expand the Making Every Adult Matter (MEAM) pilot	North Tyneside Council – Adult Social Care	Establishment of a suitable forum for assessing, risk assessing and supporting vulnerable adults who choose not to engage or fall out outside of criteria. Improved outcomes for this often hard to reach cohort of individuals measured via client feedback.	May 2014 April 2015	The MEAM coordinator was appointed in April 2014. The process of the MEAM has been agreed by Partners and the Strategic and Operational Panel are in place.
Department of Work and Pensions						
Develop protocols to improve liaison/multi	Local, but with a view to sharing good practice	Identify key stakeholders.	Department of Work and Pensions			DWP will be developing their action from July 2014

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Recommendation	Scope of Recommendation	Action to Take	Lead Agency	Key Milestones achieved in enacting the recommendation	Target Date	Date of Completion and Outcome
agency work with other agencies to ensure those with complex needs are effectively supported	nationally	Arrange meeting to explore issues/develop protocol. Implement protocol Review protocol				