15/01/2014 FINAL

SAFER
NORTH TYNESIDE

DOMESTIC HOMICIDE REVIEW:

INDEPENDENT OVERVIEW REPORT INTO THE DEATH OF "GUSTAS"

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1) THE DOMESTIC HOMICIDE REVIEW PROCESS

1.1 Who the report is about:

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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 The decision to carry out a review:

A DHR Core Group meeting on 5 June 2013, considered the presenting circumstances of the homicide. The decision of this meeting was to make a formal recommendation to the Chair of Safer North Tyneside that a DHR should be carried out. This recommendation was accepted and the Home Office was formally notified of this decision on 12 June 2013.

1.4 Review timescales:

Following the decision to carry out a review, a DHR Panel was convened and met for the first time, on 8 August 2013. The review process concluded at the final DHR Panel meeting on 7 January 2014. This final report was presented to Safer North Tyneside Board on 15 January 2014.

[1]Pseudonyms (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

1.5 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 the Community Safety Partnership has signed off the overview report and executive summary, these will be forwarded to the Home Office Quality Assurance Group, together with supporting documents.

An anonymised version of the executive summary will be published, after clearance has been received from the Quality Assurance Group.

1.6 Individual Management Reviews, Terms of Reference and time periods examined by the review:

Each of the agencies which had been identified as having significant and relevant involvement with the victim and/or perpetrator carried out an Individual Management Review (IMR) of that agency's involvement. The terms of reference included a requirement for the IMRs and this overview report to specifically address the following questions:

- If there was a low level of contact with your agency why was this so? Were there any barriers (particularly ethnic origin, culture or language) to either the victim or the accused accessing your services and seeking support?
- Was there any indication of the victim being isolated 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 accused)?
- Whether the accused had a history of any violent behaviour 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?
- Did they hold any information offered by informal 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, culture or language impact on access to services or service delivery?

The terms of reference specify that the period to be considered by the DHR would be from January 2009 until the date on which Gustas died.

1.7 DHR Contributors:

The following individuals and organisations have contributed to this DHR:

Name	Organisation	Contribution to DHR
Tom Wood	Independent Consultant	Chair of DHR Panel
Richard Corkhill	Independent Consultant	Panel Member Independent Overview Report Author
Lynne Crowe	Safer North Tyneside	DHR Coordinator
Janine Charlton	Safer North Tyneside	DHR Administrator
Stephen Blades	GP Lead for Adult Safeguarding	IMR author

Sandra Brydon	Senior External Relations Manager, Department of Work and Pensions	IMR author
Sharon Thompson	Professional Lead for Mental Capacity and Mental Health Acts, Northumbria Healthcare NHS Trust	IMR author
Peter Xeros	Operations Manager, Youth Offending Service, North Tyneside Council	Panel Member IMR author
Suzanne Howard	Adult Social Care, North Tyneside Council	Panel Member IMR author
Jan Grey	Northumberland Tyne & Wear NHS Foundation Trust	Panel Member IMR author
Joan Robson	Northumbria Police	IMR author
DCI Steve Barron	Northumbria Police	Panel Member
Colin Boxshall	Safer Estates Manager, North Tyneside Council	Panel member IMR author
Kate Spence	District Nursing Cluster Coordinator, Newcastle on Tyne Hospitals NHS Foundation Trust	IMR author

Each of the Panel members has received a copy of the report, in advance of signing off by the Community Safety Partnership and forwarding to the Home Office Quality Assurance Group. **(See section 1.5 above re confidentiality)**

1.8 Independent Chair:

Tom Wood is currently Independent Chair of both Adult and Child Protection Committees in two Scottish Local Authority Areas. He was Deputy Chief Constable and Director of Operations of a large police force in Scotland and subsequently served as a Special Adviser on Alcohol and Drug Policy in Scotland**.**

1.9 Independent Overview Report Author:

Richard Corkhill has a professional background in statutory and voluntary sector social care, including senior management of services for vulnerable young people and adults. As an independent consultant since 2004, his work with public sector organisations has included research into safeguarding adults policy and practice and production of independent reports for safeguarding adults Serious Case Reviews and DHRs.

1.10 Contact with victim's family:

The victim's immediate and extended family has been kept advised and informed about the DHR process, but they have not directly contributed. This is due partly to the risk that DHR related enquiries may have compromised criminal proceedings. Another factor is that immediate family members had returned to their country of origin before completion of the DHR. Contacts between the DHR process and the family were maintained with British Consular assistance, but the family did not actively contribute to the DHR process.

1.11 Methodology:

There have been four meetings of DHR Panel, which has been coordinated by the Community Safety Team and independently chaired. These meetings took place between 8 August 2013 (initial meeting) and 7 January 2014 (final meeting). There have also been meetings (group and individual), discussions and correspondence between the Overview Report Writer and the authors of IMRs.

Having agreed terms of reference and report formats, chronologies and IMRs were completed by each organisation which held relevant information about the victim and/or the perpetrator. In some cases the IMRs were prepared on the basis of reviews of paper and/or computer based records held by those organisations. However, in most cases, IMR authors also interviewed staff members who had had direct involvement with the victim and/or perpetrator.

Background information on the victim and perpetrator was sought primarily from local agency records. The family were recent immigrants to the UK, and these records did not include very much information about family circumstances and backgrounds, prior to their arrival in the UK. As surviving family members did not actively contribute to the DHR, this created something of an information gap for the DHR Panel.

The IMRs were presented and discussed at a meeting with IMR authors on 16 October, 2013. A first draft Overview Report was then prepared, based on the contents of the IMRs and points raised at the IMR authors' meeting. This draft Overview Report was circulated to IMR authors and Panel members and reviewed at further meetings of the Panel on 14 November, 2013 and 7 January, 2014. Agreed clarifications and amendments were made before the report was presented to the Community Safety Partnership for final approval, on 15 January, 2014.

2) FACTUAL SUMMARY

2.1 Chronology:

As part of the review process, individual agencies produced detailed chronologies of their contact with both the victim and perpetrator. These chronologies where combined to produce a comprehensive chronology of all contacts and have been used to inform this DHR.

2.2 The death of Gustas:

In spring 2013 the Gustas's body was found in his accommodation in North Shields. He had sustained various injuries, including a stab wound to his neck. A police investigation resulted in Lukas being arrested. At the time of his death the victim was in his early 20's and the perpetrator was 18.

2.3 Family structure and circumstances:

The family composition was as follows:

Name	Relationship to Victim	Relationship to Accused
Mr. A	Sister's partner	Step father
Ms. B	Sister	Mother
Gustas (victim)		Uncle
Lukas (perpetrator)	Nephew	

This family unit immigrated to the UK from Eastern Europe in 2009 and moved to North Tyneside in 2010. The DHR has not had access information about the family history prior to arrival in the UK. On arrival in North Tyneside, the family all resided at the same address, a privately rented flat in the centre of North Shields.

In April 2012 the family accepted the tenancy of a three bedroom council house in North Shields. The application for rehousing was awarded additional priority on medical grounds relating to Ms. B who was terminally ill, and overcrowding at the first address, which is a one bedroom flat.

It had been understood by the Housing Service that the whole family unit would be moving into the council property, but a subsequent housing benefit change of circumstances form stated that Gustas had in fact remained resident in the flat. However, between April and July 2012, he was visited frequently by Tuberculosis (TB) community nurses at the council property, which they understood to be his address. On this basis, there remains some element of uncertainty about where he was actually living between April and July 2012, but it is possible that he moved between the two addresses. Records show that, from 24 July 2012 until his death, he was resident in the one bedroomed flat. He did not have a formal tenancy for this address, which was described as a squat.

It is understood that the family were legally entitled to reside in the UK, although there were long periods when Gustas's benefits were suspended, whilst the Department of Work and Pensions (DWP) carried out habitual residence tests.

Ms. B, who had previously been diagnosed with a terminal cancer, died seven weeks before the homicide incident.
Mr. A, as the partner of Ms. B, is recorded as being Lukas's step-father. The information available to the DHR Panel does not provide any clear picture of this relationship, either in legal terms (i.e. whether Mr. A had Parental Responsibility) or what the nature of their day-to-day relationship was.

2.4 Gustas – victim:
As outlined at 2.3 above, at the time of his death Gustas lived alone. He had significant problems with alcohol dependency. In March 2011 he informed his GP that for the previous two to three years he had been drinking around three or four litres of cider per day. In September 2011 he was diagnosed with TB.

He was known to local agencies, including the police, specialist community TB nurses and an alcohol dependency treatment unit. Information from these agencies and others confirms that Gustas was vulnerable to exploitation by others. This vulnerability is described and discussed in more detail, in the analyses of agency involvement.

Gustas had a chaotic lifestyle, with issues of homelessness, but there is no known history of rough sleeping and he was not known to rough sleeping services. There is no evidence of any gang affiliations, though this possibility cannot be ruled out entirely, given his lifestyle. There were a number of emergency hospital admissions for problems associated with TB, alcohol dependency, and for injuries which were variously reported to be accidental or resulting from violent incidents. There were also incidents of deliberate self-

harm. He had been a victim of crime and had also committed some low level crime, including theft of alcohol from shops. He had limited command of the English language, which may well have resulted in increased levels of social isolation and vulnerability.

2.5 Lukas – perpetrator:

Lukas immigrated to the UK when he would have been around 14 years and 15, following which the family moved to North Tyneside. As there was only one term when he was of statutory school age in North Tyneside, there is very limited information about his educational background.

The only local agencies which had significant contact with Lukas prior to the homicide death were the Police and Youth Offending Service (YOS). These contacts related to the following three Police incidents:

- **Police incident 1, October 2012**

The police were called to an affray outside a pub and Lukas was arrested, along with four other eastern European males. This resulted in a "Triage 1 intervention". This is Northumbria Police area wide disposal for low level first time offences, designed to divert young people away from the formal criminal justice process.

This incident appears to have been alcohol related. Contextual information from the police and YOS IMRs suggests that Lukas's involvement was seen as being relatively peripheral. He was under 18 years old at the time of the incident and the main offenders were young adults. There is no indication that Gustas was involved in this incident.

- **Police incident 2, January 2013**

He was reported to have committed dwelling house burglary. For this offence he was given a Final Police Warning. Again, alcohol appears to have been a factor. The victim in this case was Gustas, who made a statement to the police. It appears that the two of them had been together at Lukas's address, before he went to his uncle's address, where he consumed alcohol and removed a television set. This was without his uncle's permission.

- **Police incident 3, April 2013**

This was an offence of Breach of the Peace, following which he appeared at North Tyneside Adult Court, where an Attendance Centre Order was made.

This incident was also believed to be alcohol related. It occurred at his uncle's flat. He kicked two police officers who had attended as a result of complaints about excessive noise (music). His uncle was present when this incident happened, but did not commit any offence.

3) ANALYSES OF AGENCY INVOLVEMENT

3.1 Introduction

This section considers the involvement of each of the agencies:

Agency	Significant roles in relation to victim/perpetrator
Youth Offending Service	Voluntary support following police warnings - perpetrator
Northumbria Police	Criminal justice interventions - victim and perpetrator. Emergency responses to welfare concerns – victim.
North Tyneside Council: Adult Social Care	Adult social care interventions - victim
Department of Work and	Benefits claims - victim

Pensions	
North Tyneside Council: Housing and Homelessness Services	Managing applications for housing / homelessness presentations – victim and household including perpetrator
North Tyneside Clinical Commissioning Group	GP services - victim
Newcastle upon Tyne Hospitals NHS Foundation Trust	Hospital and specialist TB community nursing - victim
Northumbria Healthcare NHS Foundation Trust	Hospital and Community District Nursing - victim
Northumberland Tyne and Wear NHS Foundation Trust	Community Mental Health and alcohol addiction - victim

Each of the above agencies is considered in turn, with reference to the respective IMR. In each case, a summary of key elements of the agency's involvement is followed by separate commentary and analysis.

3.2 North Tyneside Youth Offending Service:

The YOS was the only service other than the police which had significant contacts with the perpetrator. This was for a relatively short period, with 12 contacts between 17 January, 2013 and 5 May, 2013. He had initially been referred to YOS following police incident 1 (see 2.5 above). The referral was in line with standard Police/YOS protocols.

As there was no statutory supervision in place, YOS contact with Lukas was on a voluntary basis. The period of YOS involvement included the date of his mother's death. The last direct contact by his YOS case manager was to attend her funeral, some weeks before the homicide incident.

The third police occurred during the period of YOS involvement. However, because he had then passed his 18th birthday, this was dealt with through adult criminal proceedings. As a result of this, YOS were not aware of this incident, or his subsequent appearance at adult court, until after he had been arrested following his uncle's death.

At an initial assessment interview on 22 January, 2013, he informed his case manager that he wished to have a health check, reporting that he experienced strange thoughts *"like taking lots of energy drinks to see what happens"*. He was offered the option to meet with a Child Adolescent Mental Health (CAMH) worker seconded to YOS. He initially agreed to this meeting, but at the next meeting with his case manager withdrew consent, saying that he did not feel he needed such assistance.

An assessment was carried out by YOS, in line with National Standards for Youth Justice. His risk of reoffending was assessed as low. The IMR confirms that this was based on a standardised Youth Justice Scaled Approach:

"*This takes into account both static and dynamic factors. The accused had no previous substantive outcomes prior to the Final Warning therefore his static factors were low. In respect of the dynamic factors identified, this information was obtained solely via an Asset interview with the accused. There was no means to collaborate his perspective as neither parent was interviewed as a part of the assessment process."*

The YOS intervention plan identified four specific actions:

- Assistance with education, training and employment.
- Minimising risk associated to substance misuse.
- Work to increase understanding of the impact of future offending.
- Work to increase victim awareness.

In the main, Lukas was compliant with YOS interventions, though there were some missed appointments. When he engaged with the service he was always polite; never presented in an aggressive manner and never disclosed any ongoing conflicts with family members or the wider community. The YOS IMR confirms that the service had no information from other agencies or outside sources which could have contradicted this presentation.

Work was carried out by YOS, including a referral to their seconded Connexions advisor, which enabled Lukas to access English as a Second Language (ESL) course at Tyne Met College. Following the death of Lukas's mother, focused YOS interventions were suspended, but contact was maintained in order to provide emotional support.

Analysis

Assessment of low risk of re-offending:

As this assessment was made quite shortly before the homicide took place, it raises potential questions about the assessment process and outcomes. The IMR author for YOS confirms that the assessment process complied with national guidance, but also that there was no parental involvement in the assessment process:

"The lack of involvement of the father of the accused in the assessment process I assess as creating a one dimensional understanding of the key risks associated to the accused. The fact that the case manager accepted the accused version of events, family relationships and lifestyle did not reflect a holistic view of the case. As aforementioned, it is acceptable to assess a 17 year old without parental involvement but I accept that this is not "best practice".

The lack of corroboration of the accused version of events is also reflected in the Restorative Justice process which again has resulted in a one dimensional view of the potential risk factors associated with the victim."

This raises a question of whether parental involvement in the assessment would have been likely to change the level of assessed risk of re-offending. However, on the basis of all of the information available to the DHR, it appears unlikely that this would have highlighted a specific risk that Lukas may present a significant risk of causing serious harm to Gustas. It is also important to acknowledge that, as YOS had no statutory powers of supervision, engaging his parents in the assessment would have depended upon his consent. Additionally, it is noted that at the time of assessment he was very nearly 18 years old.

Corroboration in relation to the Restorative Justice process could have included direct contact with Gustas, as the burglary victim. With the benefit of hindsight, it is possible to observe that this could have been an opportunity for Gustas to share any concerns he might have had that Lukas presented a threat of violence. However, the DHR has confirmed that there were a number of other agencies quite intensely involved with the homicide victim and he did not express such concerns about Lukas to any of those. It seems unlikely that he would have responded differently to contact from the YOS case manager.

The YOS IMR has highlighted an important learning point, which is that an assessment of a 17 year old's risk of re-offending is likely to be significantly less reliable, in the absence of any discussion with parents.

Communication between YOS and adult criminal justice processes:
The fact that YOS were unaware of police incident 3 and the consequent court appearance is a concern which has been clearly identified by the YOS IMR. Knowledge of this incident would have resulted in a more informed assessment of risks associated with his alcohol use, violent behaviour and potential

reoffending. As a direct result of this learning, discussions have been started between YOS and Northumbria Police, to look at changes in procedures to ensure YOS services are notified of offences committed by young adults of 18 years and over, who are still in contact with YOS teams. These discussions are being supported by all six YOS teams which operate in the Northumbria Force area.

Possible mental health problems:

The self-reported symptoms of "having strange thoughts" may have been an indication that he was suffering from a mental illness. However, there appears to have been no indication that his mental health was likely to cause him to be violent to others, or to seriously harm himself. On this basis, the offer of referral to the CAMHS worker was an appropriate response. Indeed, the availability of a seconded CAMHS worker within the YOS service can be identified as an example of good practice. It is noted that the case manager was monitoring for any further evidence of mental health problems, with a view to possible re-referral to the CAMHS worker. Again, this was good practice. There was no evidence which could have suggested any form of compulsory mental health intervention would have been legally possible, or desirable.

Language issues:

It is noted in the IMR that Lukas was able to communicate and express himself adequately, but was not fluent in the English language. This would inevitably have increased risks of social exclusion, acted as a barrier to education, training and employment opportunities, thus increasing the risk of reoffending. The assistance given by the seconded Connexions worker, resulting in him accessing an ESL course is recognised as an example of good practice.

Conclusions:

The YOS IMR has positively identified a number of key learning points and specific actions, arising from the circumstances surrounding this homicide.

Whilst these are valuable lessons for the future, there is no evidence to indicate that YOS could reasonably have been expected to identify that Lukas presented a significant risk of causing serious harm to his uncle, or to anybody else.

3.3 Northumbria Police:

Police involvement with Lukas has already been outlined (sections 2 and 3.2, above).

Police contacts with Gustas were mainly related to low level crime such as theft of alcohol from shops, but also include 5 occasions when Protection of Vulnerable Adults (POVA)/Adult Concern Notifications (ACN) were raised by officers:

Date ACN raised by police	Summary of events leading to ACN
24/9/2010	Gustas was found in the river at N. Shields, having fallen in, reportedly by accident. The police incident log noted that five other eastern European males were present, but had left him in the water.
24/9/10	Gustas reported somebody kicking his door. A local male was arrested for criminal damage. Gustas was taken to hospital, suffering from signs of psychosis and alcohol withdrawal.
14/5/12	Gustas was found by police at his home address with open wounds to both wrists, which he had inflicted himself in an attempt at suicide. The officer also noted signs of old injuries to his neck – possible ligature marks. Gustas was taken to the Royal Victoria Infirmary (RVI), where he was recorded to have lost around 4 pints of blood.
28/11/12	Reported burglary to his flat, but police found no sign of disturbance. Whilst there they received a call from a taxi

	company reporting that a female they had just collected from the address failed to pay her fare. Gustas was drunk and reported that people were coming into his flat. On the same date another male was arrested for drunk and disorderly after being at Gustas's flat.
30/1/13	Reported burglary to his flat by Lukas (Police incident 2)

The Police IMR makes further reference to evidence of Gustas's vulnerability:
"On three occasions (Gustas) *was taken to hospital, once after he had cut his wrists and on 2 occasions when he was found heavily in drink and unable to care for himself. On the first occasion it was noted that he was being assessed by the Mental Health Team. There was also contact between police and a Drug and Alcohol service worker regarding a request for welfare checks in August 2012. This was due to the fact that as (Gustas) had alcohol problems it was not mental health related and as such the Crisis Team could not deal. Police were able to carry out one check and (Gustas) was fit and well."*

The Police IMR observes that none of the ACNs raised resulted in referrals on to North Tyneside Council's Adult Social Care (ASC), because Gustas did not meet the safeguarding adults criteria, based on Department of Health *"No Secrets"* [2]guidance. The IMR also notes:
"A referral should not be completed in respect of persons who do not fit the "No Secrets" definition but who have chaotic lifestyle issues such as drug or alcohol dependency."

The police officers who raised the ACNs had understood that these would automatically be passed on to ASC. In reality, internal police procedures were

[2] *No Secrets: Guidance on Developing and Implementing Multi-agency Policies and Procedures to Protect Vulnerable Adults from Abuse*. Department of Health, 2000.
https://www.gov.uk/government/publications/no-secrets-guidance-on-protecting-vulnerable-adults-in-care

filtering out ACNs, because Gustas had a chaotic lifestyle and alcohol dependency problems.

On 14 January, 2013, the police carried out a risk assessment on Gustas as a repeat crime victim. This assessment concluded that he was at medium risk of repeat crime, 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. It is noted in the Police IMR that he did not pass on any details to police of any support workers that were in contact with him.

The police IMR makes it clear that they received no information, from Gustas or any other sources, which could have suggested that he was at risk from domestic violence from Lukas, or from any other family member.

Analysis

Police view that Gustas did not meet the safeguarding adults criteria, as set out in No Secrets:

The DHR has considered the issue of whether or not Gustas met the definition of a "vulnerable adult", as set out in the No Secrets guidance, which defines a vulnerable adult as a person who is:

- *over 18*
- *is or may be in need of community care services by reason of mental or other disability, age or illness and*
- *is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation.*

(For the purposes of No Secrets guidance, community care services are taken to include all care services, provided in any setting or context.)

There is nothing in this definition or the wider No Secrets guidance which would exclude somebody from being defined as vulnerable, solely on the basis that they

have a chaotic lifestyle or are alcohol dependent. Therefore, the assertion in the police IMR that Gustas did not meet the No Secrets definition is incorrect.

No Secrets points out that vulnerable adults may be abused by:
"…a wide range of people including relatives and family members, professional staff, paid care workers, volunteers, other service users, neighbours, friends and associates, people who deliberately exploit vulnerable people and strangers"

Based on the above observations, it may be argued that the ACNs, having been raised by front line police officers, *should* have resulted in referrals to ASC, on the basis that Gustas was a vulnerable adult and there was evidence that he was at risk of abuse by others. This view is supported by the Police's own assessment that he was at medium risk as a repeat crime victim, on the basis of evidence that local people of no fixed abode were attending his address and taking advantage of him.

It is recognised that only one of the ACNs made any reference to Lucas as a possible perpetrator. This was an offence of theft, rather than violence. As such, it would very probably not have raised a concern that he presented an immediate risk of violence. However, it is possible that referral of this incident to ASC may have led to a more careful assessment of the relationship between Gustas and Lukas.

An important point is that isolated "low level" incidents may not give rise to significant concern. However, as highlighted by a number of adult safeguarding Serious Case Reviews,[3] where there are a series of such incidents involving a vulnerable adult, this can build a picture of somebody who is at risk of significant harm. A single referral may not result in an active adult safeguarding response,

[3] For example, see SCR into the death of Steven Hoskin, including recommendations about risk criteria and thresholds for safeguarding adults. *Margaret C Flynn for Cornwall Safeguarding Adults Board, Dec 2007.* http://www.cornwall.gov.uk/Default.aspx?page=5609

but a pattern of similar incidents over a period of time should be more carefully assessed as a possible safeguarding concern. If referrals are filtered out before reaching ASC, such an assessment seems unlikely to happen.

The DHR has been advised that there had previously been discussions between the Police and ASC, about the large volume of ACN referrals resulting from alcohol related incidents. On the basis of these discussions, it was agreed that those who are severely self- neglecting as a consequence of the misuse of alcohol should be referred for a community care assessment (not safeguarding) whilst others will be capacitated and perfectly content with their lifestyle and neither require or want any support from ASC. The three categories agreed with the Police were:

- **Referral:** Where there is an allegation or suspicion of abuse or neglect and a vulnerable adult is believed to be at risk of significant harm. (*This would be a referral for an immediate safeguarding response)*
- **Notification:** Where there is a concern that an adult requires additional care/support but they have not consented to, or do not have the capacity to consent to a referral to ASC. (*No concern re: abuse or neglect but 'one to watch' in the Steven Hoskin sense of multiple notifications/alerts becoming a problem where a single one was not).*
- **Request for a community care assessment:** Where there is a concern that an adult requires additional care/support and they have consented to a referral to ASC for this reason. (*Again, no concerns about: abuse or neglect)*

Following further discussion between the adult safeguarding leads for North Tyneside, Northumberland and Newcastle Councils it has been confirmed that these definitions remain appropriate. However, the police view (as reflected in the IMR) that Gustas did not meet any of these definitions indicates that interpretation is inconsistent. This issue is explored further in the following section 3.4, which considers ASC responses.

Front line officers' understanding about criteria for passing on ACNs to ASC:

The concerns outlined above are compounded by the fact that operational officers had believed that ACN concerns *would* result in a referral to ASC, meaning that they would be less likely to consider other possible strategies to reduce risks (for example, working with local voluntary agencies).

The Police IMR has identified an action point, which is to ensure officers are aware of the criteria for referring vulnerable adults. However, the above analysis suggests that the primary issue is whether or not the interpretation and application of the criteria themselves (i.e. not passing on concerns to ASC, because the vulnerable adult is alcohol dependent and has a chaotic lifestyle) can provide adequate protection for vulnerable adults with chaotic lifestyles and alcohol problems, where they are known to be at risk as repeat victims of crime.

It is acknowledged that vulnerable adults with alcohol dependency and chaotic lifestyles present major challenges for police, ASC and other services, not least because attempts to establish effective adult safeguarding plans may be repeatedly undermined by the behaviour of the subject of the safeguarding plan. Even if the police had passed on every ACN to social services, it seems unlikely that social care interventions could have prevented Gustas from continuing to consume excessive quantities of alcohol and making himself vulnerable to harm from others. But the response to this challenge should be to develop services which are better equipped to meet complex needs.

As a direct result of learning from this case, Northumbria Police are working with adult safeguarding leads in North Tyneside, Northumberland and Newcastle Councils, to review thresholds for raising alerts and to ensure there is mutual agreement and understanding of what constitutes a suitable adult safeguarding referral.

3.4 North Tyneside Council Adult Social Care Services:

The IMR for ASC provides a detailed description and analysis of ASC's periodic involvement with Gustas, between September 2010 and January 2013. ASC involvement was in response to contacts from a number of agencies, including Northumbria Police and a range of NHS services which were involved as a result of accident and emergency attendances, admissions for treatment of alcohol withdrawal symptoms; community and in-patient TB treatments and an attempted suicide.

The initial contact was an ACN from Northumbria Police, following the incident on 25 September, 2010, when Gustas had been rescued from the River Tyne. This did not result in any direct contact by ASC with Gustas, apart from a telephone call following his hospital discharge, when he advised a duty social worker that he was feeling better.

In February 2012, there was some brief contact with a TB nurse, who had requested support with housing and benefits issues, but no direct contact between ASC and Gustas.

In May 2012 there was some involvement from a hospital social worker at the RVI, where Gustas had been admitted following a suicide attempt. The social worker carried out a risk assessment, which indicated significant risk in several areas. However, on discharge he was not referred for ongoing involvement from ASC in North Tyneside. The IMR indicates that this was because Gustas was felt to be sufficiently supported by ongoing involvement from the community TB nursing service and from Plummer Court, Drug and Alcohol Addictions Service where he had Community Psychiatric Nurse (CPN) involvement.

On 20th June 2012 a Senior Social Worker from the ASC Safeguarding Team attended a multi-disciplinary meeting which was convened by the Health

Protection Agency (HPA), due to concerns that the TB diagnosis (and problems in relation to compliance with medication) could present a public health risk. The IMR completed for ASC makes the following observations:

"(Gustas) *was described as a "fully capacitated adult" and the Senior Social Worker thought it unlikely he would be eligible for services under Fair Access to Care Services criteria (FACS). As a consequence she refused funding for daily trips to the hospital for medication although this was arguably a health rather than a social care need anyway. The entry recorded in AIS (Adults Integrated Solution database) makes no mention of previous requests for assessment notably that received from the RVI on the 23rd May 2012, nor does it lead to a referral to the Welfare Benefits Team. The latter is possibly because the Benefits Team worked exclusively with ASC clients at that time and (*Gustas*) was not then allocated to a care manager. It is understood the Multi-Disciplinary Team (MDT) meeting requested a social care assessment"*

On 13 August 2012 a social worker was allocated to complete the requested assessment. This was around eight weeks after the request, but the reasons for this delay are not known. The IMR notes:

"When interviewed the Social Worker said she did not consider (him) to be a dependent drinker at the time of her involvement because he was able to abstain from drinking for lengthy periods. The Social Worker was aware of Plummer Court's (Northumberland Tyne and Wear NHS Foundation Trust Addiction Service) involvement but was largely unaware of previous entries on AIS detailing a chaotic lifestyle and psychotic episodes associated with alcohol withdrawal, both indicators of dependency.

(Gustas) *told the Social Worker he felt at risk of harm when drinking alcohol. He also presented risks to self and others from unmanaged TB but Social Worker did not complete a FACE (core assessment and outcomes package for health and*

social care) risk assessment during her involvement. Instead she requested a copy of the risk assessment completed by the CPN and remembers receiving it but it is not mentioned in case notes or scanned on to ESCR (Electronic Social Care Records)."

The social worker remained involved and during August 2012 attempts were made to advise and assist Gustas with his Housing Needs and Housing Benefits. At the end of August, the Council's Welfare Benefits Team also became involved in trying to help him resolve the ongoing problems with his benefit claim. This eventually led to the award of a backdated payment of over £2000, in November 2012 (see 3.5 below for further detail). The Welfare Advice Officer (WAO) was aware of the probability of a large back payment and possible risks associated with this were discussed with the allocated social worker. Both the WAO and the Social Worker believed they could do no more than suggest risk management strategies, because Gustas was a capacitated adult who was entitled to receive and manage his own money.

Analysis

The IMR for ASC is a detailed, robust and frequently self-critical analysis. It highlights significant learning about the ways in which adult care services work with people who do not 'fit' the traditional picture of an adult with social care needs. Most importantly, it has resulted in an action plan which aims to translate these lessons into positive changes.

The following is a brief summary of some of the key issues for ASC:

Opportunities for assessment:

There were a number of points between September 2010 and January 2013 at which referrals to ASC were made by the police and health services. In some cases there was an initial screening assessment, but not all opportunities for a

full assessment of needs and risks were taken. The IMR reaches the following conclusion:

"Opportunities to comprehensively assess the victim's needs were missed by numerous social care teams. The one community care assessment that was completed failed to build on previously recorded risks, involvements and assessments to form a holistic picture of his needs"

Fair Access to Care Services (FACS):

The IMR provides an outline of the legal framework around FACS, including case law on the duty to assess needs, noting that there can be confusion between the duty to assess and the duty to meet eligible needs. It makes the following observation:

"In spite of a catalogue of health conditions and repeated references to exploitation, unsafe housing, the absence of any funds for food and utilities, he was twice deemed ineligible for services under FACS. His social worker did however provide a service, that of professional support. This is a service most authorities provide but as a non-chargeable service it is seldom recorded as a service."

In its conclusions the IMR refers to widespread (i.e. not just in North Tyneside, but within the social work profession) interpretation of FACS and eligibility

"…… in terms of traditional 'needs', i.e. activities of daily living such as washing, dressing, eating, mobilising etc. In response 'services' are seen as the means of meeting those traditional needs and such an interpretation can screen out some with less obvious needs at the outset"

Helpfully, the IMR references DoH guidance (1993) which makes it clear that local authorities are expected to attach high priority to alcohol and drug users in community care, to take account of their special circumstances and to ensure

that eligibility criteria are sensitive to their circumstances. But the IMR notes that not all of the eligibility criteria included in North Tyneside's procedural documents takes account of the 1993 DoH guidance.

Language and Culture

Gustas's first language was not English, but at no point did ASC services employ an interpreter. There was reference to him having some difficulty with official language and forms, although his ability communicate verbally in English was reported to be quite good. The IMR concludes:

"Although the social worker asked him if he wanted an interpreter, none of the workers involved paid sufficient attention to issues of language and culture. Similarly he was facing cumulative discrimination based on his immigration status, employment status and two stigmatising conditions but the disabling impact of this was never recognised."

Alcohol dependency and Mental Capacity Act:

The IMR explores the issue of mental capacity, recognising that Gustas was assumed as having capacity, even when making what most people would consider very unwise choices in relation to alcohol consumption, medication compliance and the people he allowed into his home and associated with. However, it also presents a possible challenge to this assumption:

"When drug or alcohol use has reached the point of dependency, it is debatable whether the individual is still capable of free, informed decision making. For some, satisfying their addiction may deprive them of all but the most rudimentary autonomy rendering their decisions not just unwise, but uninformed by any other factors"

The above observation highlights an important area for discussion and potentially a need for multi-agency policy, guidance and training. However, the evidence available to this DHR does not offer a reliable basis for any retrospective

judgment on whether or not Gustas possessed or lacked capacity, in the context of historical events and his ability to make informed decisions.

Tuberculosis in vulnerable groups:

The IMR references National Institute for Health and Clinical Excellence (NICE) public health guidance, *Identifying and Managing Tuberculosis Among Hard-to-Reach Groups (March 2012)* which lists four groups as being most at risk:

- Vulnerable migrants
- People who misuse alcohol or other substances
- Homeless people
- Prisoners

Gustas fell into at least three of these four categories. (It is unknown whether or not he had been in prison prior to arrival in the UK)

Other elements of the NICE guidance and their relevance to services' responses to Gustas are highlighted in the IMR:

"Multi-Disciplinary TB Teams (MDTB) should seek to address social and cultural barriers to accessing services including fear, stigma and staff attitudes. In this case, social care and housing staff were given conflicting information about his condition, in particular whether he was contagious and this led directly to him being denied a housing related floating support service and a drop-in / day service.

NICE also suggest misinformation can lead to concerns about housing people with TB and questions were often asked by homeless officers about his infection risk. NICE recommend that MDTB teams should:

….. work together to agree a process for providing accommodation for homeless people diagnosed with active pulmonary TB who are otherwise ineligible for state

funded accommodation. The process should detail the person's eligibility and ensure they are given accommodation for the duration of their TB treatment"
(As quoted in the IMR, from the NICE guidance document*)*

In fact, Gustas was technically eligible to apply for social housing and claim housing benefit, but delays and confusion with his benefits claims meant that he was effectively excluded from accessing social housing. At the same time, he was excluded from housing related floating support, due to concerns about TB infection risks. These issues are considered further, in the following two sections which review involvement of the DWP and North Tyneside Housing, respectively.

Conclusions:
There are wide ranging concerns and questions about how ASC responded to the needs of Gustas. It should be recognised that he presented with a very challenging set of behaviours, needs and risks. The IMR and the resulting ASC action plan demonstrate a determination by this agency to learn from any shortfalls in policy, procedures and practice which have been highlighted.

Although these concerns have been identified in the context of a DHR, the central issue was the ability ASC to respond to the needs of an adult whose vulnerability stemmed primarily from excessive alcohol consumption and having a chaotic lifestyle, in close association with similarly chaotic people. This was in addition to suffering from a life threatening illness, often being non-compliant with medication and presenting a potential public health risk. The challenges of providing effective social care and adult safeguarding services to such an individual should not be under-estimated.

Summary:
There were aspects of the ASC response which fell short of best practice. However, Gustas's alcohol dependency and lifestyle meant that he was always

likely to be vulnerable to violence and abuse by others, even if there had been an earlier and more thorough assessment of his social care needs.

ASC, in common with all of the other services he was in contact with, had no reason to be concerned that there was any specific risk of violence from Lukas, or any other family member. On this basis, it is recognised that shortcomings in ASC interventions did not contribute directly to the circumstances leading to the homicide.

3.5 Department of Work and Pensions:

DWP hold records relating to benefit claims made by Gustas, from May 2011, when he claimed Job Seeker's Allowance. The DWP IMR includes a detailed account of a series of benefit claims which show that, for long periods, he received no benefits. His Job Seeker's Allowance (JSA) claim dated 16 May, 2011 was delayed by around 15 weeks whilst a Right to Reside/Habitual Residency Test (RTR/HRT) was carried out. This claim was eventually paid in the September, but Gustas then changed his claim to Employment Support Allowance (ESA) and his JSA claim was closed. Whilst it was subsequently established he was entitled to ESA, this was subject to his RTR/HRT for ESA purposes, for which he did not meet the conditions (which differ to the conditions for receipt of JSA).

He made a new JSA claim in April 2012, which was subjected to a new RTR/HRT. This resulted in a back dated JSA payment (for the period 19th April - 5th June) This meant he had received no benefit payments for nine months, then received a backdated payment, covering seven weeks JSA.

In October 2012 he made a new claim for ESA. At around the same time his JSA was disallowed for two weeks (24 October to 6 November) on the basis that he was not actively seeking work In December 2012 and January 2013 he received back dated ESA payments including two lump sums of £719 and £2014,

respectively. These payments were made in error, as he did not meet the RTR/HRT conditions for receipt of ESA. As the payments were due to official error, they were not recovered from Gustas. He received no further benefits from 25 January, 2013.

In addition to the claims processes outlined above, the DWP IMR highlights some additional evidence of Gustas's vulnerability:

- His Jobcentre Advisor noted that he had a good grasp of the English language, although another DWP officer recorded that he had very limited English. The latter was a call centre service, which may help to explain differing perceptions.
- His Jobcentre Advisor was aware that he was vulnerable, due to substance misuse problems and self-harming behaviour. When he failed keep an appointment on 31 July 2012, she was sufficiently concerned to contact the police. They forced entry to his flat, where they found him asleep and then took him to hospital for a medical check.
- He made claims for crisis loans on 26 March, 2012 and 23 October, 2012, both of which were refused on the basis that there was no risk to health and safety. He made another crisis loan application on 16 November, 2012 and was paid £60. On 20 November, 2012 he was referred to a food bank.

DWP held minimal information in relation to the alleged perpetrator and nothing of relevance to the DHR. They held no information which could have suggested that Gustas was at risk from domestic violence.

Analysis

Delays in processing benefits claims and back-dated payments:
Gustas benefits claims were not efficiently processed. The IMR makes it clear that this was, to a significant extent, caused by failures and weaknesses within DWP systems. The repeated claims for ESA, to which he was not entitled, also

raise questions about the quality of advice and advocacy he may have been receiving from other agencies.

Consequently, a very vulnerable individual with alcohol problems and suffering from TB lived for periods of up to nine months with no apparent means of financial support.

He then received some very large back payments of benefit, including a payment of over £2000 in January 2013, even though he was not entitled to it. Bearing in mind the Police's assessment that he was at risk of repeat crime as a result of local people staying at his address and taking advantage of him, it seems very probable that the problems with his benefits claims will have added significantly to this element of risk.

Concerns about Gustas's vulnerability:

It is notable that the Jobcentre Advisor took the very unusual step of calling the police, when Gustas failed to attend an appointment. This shows that the Advisor was acutely aware of his vulnerability. It is to the Advisor's credit that she communicated her concerns to the police, who were then able to take appropriate action to ensure his immediate safety and wellbeing. This is an example of local good practice and inter-agency cooperation.

However, it also has to be recognised that, even though the local DWP office had clear evidence of him being a highly vulnerable claimant, no priority was given to making sure that claims were dealt with in a timely or efficient manner.

The problems with his benefits also impacted negatively on an application to the council for more suitable housing (See section 3.6). As he was in an unsuitable and insecure squat, this further increased levels of vulnerability.

It is understood that DWP in this region are now putting in place Advisors who will deal specifically with customers who have multiple disadvantages and chaotic lifestyles. It is envisaged that they could also act as a single point of contact for other agencies and professionals who need to contact DWP about urgent issues affecting the claimant. Given the learning from this DHR, this is recognised as a very positive step, which will hopefully improve future experiences of other vulnerable claimants. DWP advise that they will be testing and learning from this approach, so it is hoped that the lessons arising will be shared with the Safer North Tyneside.

In summary, Gustas benefit claims were poorly managed and processed as a result of systems failures, leading to significantly increased levels of vulnerability. This vulnerability was caused by periods of having no income, followed by very large payments, which would have greatly increased his risk as a potential victim of financial abuse and crime.

It is clear that DWP had no information which could have indicated that he was at any specific risk of domestic violence, so there were no actions which they could have reasonably been expected to take, which could have directly prevented the homicide from occurring.

3.6 North Tyneside Council, Housing:

Until April 2012, the entire family unit (Gustas, Lukas, Lukas's mother and his step-father) were all resident in the one bedroom flat. On 2 April, 2012 they accepted the tenancy of a three bedroom council house, having been awarded additional priority for housing, as a result of Lukas's mother's medical condition.

Although Gustas had been expected to move to the council property, in May 2012 he made an application for council housing, having apparently remained in the flat. As he did not provide proof that he was working or in receipt of benefits, this application was not activated.

Gustas again applied for council housing in August 2012, with support from a council social worker. The application was accepted, but he was placed in band 4, which is the lowest priority.

On 22 January, 2013, Gustas presented to the Council as homeless, following a hospital discharge. (The combined chronology confirms that he had been admitted to North Tyneside General Hospital on 15 January, 2013, having collapsed with alcohol withdrawal symptoms). He explained that his flat was a squat and in very poor condition. He also informed the Housing Advice Officer (HAO) that things had been taken from him, he was forced to get drugs and alcohol for others, he was threatened and that a named individual had attempted to stab him. The named individual was not Lukas. He was offered temporary accommodation, but declined as he said he could stay with his sister that night.

The HAO did not pass on the allegations (i.e. of being forced to get drugs and alcohol and the attempt to stab him) to the police, or any other agency. There is also no record of the HAO advising or encouraging Gustas to report these matters to the police. The IMR author for North Tyneside Housing confirms that he passed this information to the Police Senior Investigating Officer on 24 September 2013, as this could have been relevant to the criminal proceedings for the homicide.

On the following day Gustas failed to keep an appointment with the Housing Advice Team, so this was followed by a telephone call to him on the next day, 24 January, 2013. Gustas informed the HAO that he was able to continue staying with his sister.

On 25 January, 2013, Housing Advice referred to the Council's Gateway Team, requesting referral on for a floating support service (i.e. a service which specialises in working with people with a support need to maintain their tenancy, which can be delivered wherever the service user is located).

The referral was rejected, reportedly on the basis that the only suitable provider, Depaul UK, considered that Gustas would present too high risk to workers, as a result of his alcohol consumption whilst on medication for TB. It is understood the main risk factor was felt to be that workers would be exposed to potential TB infection, if Gustas did not comply properly with the medication regime. The basis for this judgment was the information supplied by the Gateway Team, including a number of references to Gustas presenting a public health risk, especially when using alcohol.

No IMR was sought from Depaul UK, but their regional manager has since made enquiries, at the request of the DHR Panel. These enquiries confirm that a referral was received on 29 January, 2013 and rejected on 31 January, 2013. Records reviewed by the regional manager appear to confirm that a primary reason for rejecting the referral was concern about possible TB infection risks to staff, although Depaul UK's Manager also points out that the high level of support needs presented in the referral information would also have been likely to result in rejection, as the service is not contracted as a high needs service.

There is no record (held by Depaul UK or the nursing service) to indicate that the decision was based on specialist advice from the named TB nurse whose details were included in the referral information sent to Depaul UK. There is also no record (held by Depaul UK or the Gateway Team) to suggest that the decision to reject the referral was challenged by the Gateway Team. Depaul UK point out that their Service Level Agreement with the Council describes an option which allows any decisions by Depaul UK to reject referrals, to be challenged. Depaul

UK's Regional Manager has been advised by his staff member that the Gateway Team confirmed their agreement with the decision not to provide a service.

The council's Homefinder Team identified a one bedroom council flat and contact was made with Gustas on 6 March, 2013, with the intention of offering him the tenancy. However, Gustas advised that he was not in receipt of any benefits. He said he did not know why his ESA payments had stopped, or if he would be eligible for payments. As a result of this he was advised that he was not eligible for a council tenancy. He was advised to contact them again, if he became eligible for benefits.

Between 5 April, 2013 and 10 April, 2013 the Housing Advice service had some telephone contacts with one of the community TB nurses and a friend of Gustas's about concerns that he was about to become roofless, as the property company which owned the flat intended to take legal action to make him vacate the property. A HAO spoke to the property company, who advised that there was no such intention.

North Tyneside Housing's IMR reports no significant contacts with the alleged perpetrator, or any information which could have indicated that Gustas was at a specific risk of domestic violence.

Analysis

Allegations by Gustas that he had been forced to get drugs and alcohol and that a named individual had threatened to stab him:

As this allegation suggested that an identified individual had committed serious criminal offences against a vulnerable adult, it is not clear why this was not reported to the police. Similarly, it raises the question of whether an adult safeguarding alert should have been raised under local multi-agency adult safeguarding procedures. At the very least, the HAO may have been expected to

discuss the possibility of police involvement and/or a safeguarding alert with Gustas, but it appears that no such discussion took place.

This allegation did not implicate the perpetrator of the homicide. However, police involvement and an adult safeguarding alert at this point would have presented an opportunity for a multi-agency assessment of risks, potentially followed by actions to minimise such risks.

Depaul UK's refusal to offer floating support service:

All of the available evidence from Depaul UK, the Gateway Team and the specialist TB nursing service indicates that the refusal to offer a service was not informed by advice from medical professionals with expertise in the risks of TB transmission. At this time, TB specialist and community nurses were visiting Gustas on a daily basis and were presumably confident that they were sufficiently protected from any personal risk of infection. It is therefore difficult to understand why, with appropriate advice and support from the TB nursing team, it was deemed to be too high risk for a floating support service to be offered.

It is also of concern that Depaul UK's decision appears to have been accepted without question by the Gateway Team. It is reasonable for service providers to have the "final say" on whether or not they can manage risks (to staff or others) and deliver a service. However, the Gateway Team, which is managed directly by the Council contracting Depaul UK to provide this service, could have challenged the decision. In doing so, they could have asked for a properly evidenced risk assessment, including specialist advice about appropriate management of any TB transmission risks. Management of the Gateway Team has transferred from Housing to ASC. It understood that they now have a clearer role in reviewing – and where indicated challenging - any decisions by providers not to offer a service, following a referral from the Gateway Team.

Depaul UK's regional manager advises that his enquiries are continuing, but he has identified some additional questions and potential learning points for his agency:

- Was consideration given to the possibility of telephone based advice and support, if there was evidence of an unmanageable health risk?
- Was there discussion with the Gateway Team about what would be the best service or package of services, to meet Gustas's needs? (Although, following further investigation, Depaul UK have established that their worker did suggest the Gateway Team should consider referring to a specialist alcohol service.)

On the last point, the ASC IMR suggested that supported housing could have been considered as an alternative option to floating support.

This represents a missed opportunity; as floating support (or supported accommodation) could potentially have helped Gustas reduce levels of chaotic behaviour, engage more consistently with alcohol dependency services and to resolve ongoing issues with benefit claims and housing applications. Any progress in these areas would have helped to address a range of risk factors.

Ineligibility for housing due to suspension of benefits:

This was another missed opportunity to reduce risks. If Gustas had been re-housed at this point, he would have been living in accommodation which was physically more secure. He would also have been removed from a squat where he had been identified by the police as being at risk from local people of no fixed abode, who were attending his address and taking advantage of him.

It is probable that such people would have continued to target him, at his new address. However, a move to more suitable and stable accommodation could possibly have reduced risks. This possibility could have been further enhanced,

had Gustas been assisted by a floating support service, at the point of transition from the squat, to the council tenancy.

It is understood that the council had no option but to withdraw the tenancy offer, because Gustas was not in receipt of benefits. However, the indications (from the DWP IMR) are that he may actually have been entitled benefits at this time. This provides further evidence that the problems with his benefits claim contributed significantly to levels of vulnerability.

As outlined by the ASC IMR, NICE guidelines for working with homeless people with TB infection suggest that a need suitable housing should have been considered as part of the multi-disciplinary plan, even if it had been established that he was not eligible for benefits. In this case, a multi-agency agreement on meeting accommodation costs would have been necessary.

3.7 North Tyneside Clinical Commissioning Group:

The IMR on behalf of the Clinical Commissioning Group (CCG) reviewed GP records relating to both Gustas and Lukas. Lukas had minimal contact with the GP Practice, none of which is of relevance to the DHR terms of reference.

Gustas registered with the Practice on 17 February, 2011. He reported that he had alcohol problems and had been drinking three to four litres of cider a day, for the previous two to three years. He was referred to Plummer Court, a specialist alcohol treatment service provided by Northumberland Tyne and Wear NHS Foundation Trust (see section 3.10). In September 2011, following several appointments for chest pain/chest infections, he was diagnosed with multi-drug resistant TB.

GP records confirm that he had a number of hospital admissions, between December 2011 and October 2012. These were variously for shortness of breath and chest pains, alcohol withdrawal symptoms, an incident of self-harm (lacerated wrists), and a fractured right elbow. These hospital admissions are discussed further in the sections relating to the respective NHS Foundation Trusts. The practice identified Gustas as having a high "LACE" score (a measure of risk of hospital re-admission) which meant he was discussed at monthly review meetings. The IMR noted that the individual patient record did not make reference to the high LACE score.

As he was under the care of a range of NHS services, including specialist interventions for TB and alcohol dependency, it was considered that no further action was needed in response to the high LACE score.

Hospital letters indicated that there had been multi-disciplinary team meetings to discuss Gustas's treatment, but there was no record that information was sought from the GP practice, in advance of these meetings.

Analysis

Gustas's self-reported history of excessive alcohol consumption is further confirmation of his vulnerability. There is no evidence to indicate that the GP practice could have identified him as being at risk from domestic violence.

The use of LACE measures and monthly review meetings of patients with high scores is recognised as good practice. However, as a result of learning from this DHR, the CCG will be recommending that practices should consider making a record of such review meetings, in individual patient records.

The IMR observes that it would have good practice for the GP Practice to have been asked for any relevant information in advance of multi-disciplinary discussions about a patient who clearly had complex needs. However, in this

specific case, the practice appeared not to hold any additional information which would have resulted in any improvements in treatment and management plan.

3.8 Newcastle Upon Tyne Hospitals NHS Foundation Trust: Specialist TB community nursing and hospital admissions to RVI, Newcastle

From diagnosis in September 2011 until his death, Gustas's TB treatment was overseen by a Consultant Physician for Infectious Diseases and Tropical Medicine. Throughout this period, he had frequent contact with the specialist TB community nursing team and several admissions to the RVI for treatment of his TB and for management of alcohol related problems, withdrawal symptoms and detoxification. Nurses were visiting him on a daily basis, to supervise his compliance with prescribed TB medications, though there were occasions when he was not at home for visits, or nurses could not gain access because he was in an alcohol induced state of unconsciousness.

In May 2012, he had a hospital admission following a reported self-harming incident and needed surgical closure of wounds to both arms, blood transfusion and further alcohol withdrawal treatment. The ambulance service had estimated that he lost around four pints of blood, indicating a serious suicide attempt. On this occasion, he was discharged to his sister's address, but was reported to have moved back to the flat in July 2012. Between July 2012 and his death, the IMR and chronology shows that he continued to drink excessively and was often found by visiting nurses to be extremely intoxicated, on occasions semi-conscious and requiring emergency admissions.

The IMR also shows that the community nursing services made considerable efforts to support Gustas to engage with alcohol dependency treatment services

at Plummer Court, including providing transport and accompanying him to some appointments.

Referrals were made to ASC in March and August 2012, requesting support with social problems and housing needs.

The IMR notes that when nurses visited there were often numerous men in the flat, but that those present were always polite and the nurses did not feel threatened by their presence. One of the nurses reported that when under the influence of alcohol, he might express low mood, appear anxious and on occasion say he was scared. When asked why he was scared, he would not elaborate.

Analysis

The IMR for this service confirms that Gustas was a highly vulnerable individual, due to physical and mental health problems, combined with major problems of alcohol misuse and dependency.

The chronology and IMR show that the specialist TB community nursing service made extensive efforts to try and ensure compliance with the TB treatment regime, for the sake of his own health and as a public health measure. It is also noted that the service made very considerable efforts to keep him engaged with the specialist alcohol treatment service at Plummer Court. Referrals were also made for support from ASC. These are identified as examples of good multi-disciplinary working.

On occasions when under the influence of alcohol, Gustas told one of the nurses he was scared. It should not be assumed that this fear was related to threats of violence. Whilst this is a possibility, he could also have been referring to non-specific feelings of anxiety. Attempts were made to explore this with him further,

but as he did not disclose any specific reasons for being scared, the nurse could not have been expected to take any further action.

In summary, Gustas received intensive contact from this service, which was appropriately focused on his health needs and wider public health concerns, resulting from his TB diagnosis. It is also acknowledged that the service went to considerable lengths to work in an effective partnership with the specialist alcohol service.

Whilst it was clear to the specialist TB nurses that Gustas was a highly vulnerable individual, there is no evidence that the service could have identified a risk of domestic violence, or to have taken any additional steps in respect of such a risk.

3.9 Northumbria Healthcare NHS Foundation Trust: Community nursing and emergency care hospital services

During the period covered by the terms of reference, Gustas attended accident and emergency on 8 occasions and received three episodes of care from community district nursing services.

Hospital attendances are summarised as follows:

24/09/2010 (Same day discharge)

He was treated for hypothermia, following the fall into the river Tyne. He was also given advice about his alcohol consumption. The chronology makes reference to medical notes when the background to this incident was discussed with Gustas. His explanation was that his friends were present, but didn't know what to do. He said he was in the water for 10 minutes, before a passer-by threw in a life ring and called the ambulance and police services.

25/09/2010 – 26/09/2010

Attended Accident and Emergency (A&E), complaining of hallucinations and chest pain. The hallucinations were assessed as being related to be alcohol withdrawal.

6/05/2011 – 07/11/2011

Presented at A&E (self-referral via ambulance). He was admitted overnight and treated for alcohol withdrawal symptoms. It was noted that he had input from Plummer Court.

8/9/2011 – 23/09/2011

Presented at A&E (self-referral via ambulance) complaining of hallucinations, rib pain and cough. Reported to have been drinking heavily for previous five days. During this admission he was tested for TB, which proved positive.

17/12/11 – 18/12/11

Presented at A&E (self-referral via ambulance) complaining of lower rib pain. He self-discharged on 18/12/11, but returned later in the day. At this stage, there were public health concerns, due to non-compliance with community based treatment for his TB. Following consultation with one of the community TB nurses and the infectious diseases consultant at the RVI, he was transferred to the RVI for further treatment (See section 3.8).

31/07/2012 – 1/8/2012

Was taken to A&E by police who had visited at request of a DWP employee, who was concerned for his welfare. The police had found him to be unwell and intoxicated. He was admitted, but then discharged himself on the following day, against medical advice.

15/01/2013 – 22/01/2013

Attended A&E via an ambulance called by the community TB nurse. The nurse had found him collapsed, at his home address. The IMR notes that he was very confused and agitated, sustained two falls and repeatedly tried to leave hospital. He was treated for alcohol withdrawal and TB.

On this occasion, Gustas was not allowed to discharge himself. He was assessed as lacking mental capacity to make a decision to self-discharge. A Mental Capacity Act (MCA) "best interest decision" was made that he should remain in hospital.

The IMR also makes the following notes in relation to this hospital admission:

- A friend of Gustas's raised a concern that friends or lodgers living with him were taking advantage of him and allegedly taking money off him.
- A referral was made to a social worker which highlighted concerns of 'friends' taking advantage of him and those of his housing situation.
- There was contact with housing services.
- On discharge Gustas was provided with patient transport, to go to the Housing Advice service.

Analysis

The outcome of the MCA assessment suggests that (at this point in time) he was very vulnerable, even though it is recognised that the assessment would only have assessed capacity around the specific issue of a decision to discharge himself.

There is reference in the IMR to a friend, but it is not clear whether or not this friend was consulted in relation to the decision to keep Gustas in hospital. Following treatment, he was no longer assessed as lacking capacity.

The concerns raised by the friend in January 2013 (i.e. people taking advantage of him/taking his money) could have been considered as a vulnerable adults

safeguarding concern about alleged financial abuse, but for the fact that he was not recognised being a vulnerable adult, as defined by No Secrets.

It is notable that Gustas had received a back dated benefit payment of £2014 in December 2012, which adds credibility to the allegation of financial abuse, though it is accepted that hospital based staff could not have been expected to know this detail.

A referral was made to ASC as a result of these concerns, but this was not processed by hospital staff, as a formal alert within local multi-agency adult safeguarding procedures. Northumbria Trust's IMR acknowledges that this referral to ASC did not explicitly identify Gustas as a vulnerable adult:

"Whilst referral to social services regarding these concerns was done immediately, health staff did not raise the issues as a vulnerable adult at risk of financial abuse on Trust initial concern document PROTECT. As such there is no evidence that he was considered a vulnerable adult within Trust safeguarding vulnerable adult policy. The use of a PROTECT to consider these issues, may well have supported our social care colleagues by highlighting the aspects of potential financial abuse for closer scrutiny. However as a now capacitated adult consenting to referral to social services and engaging with the Housing Advice Team, it is not a given that he was in fact unable to protect himself from significant harm or exploitation at that time."

Bearing in mind all of the information available to hospital staff about his alcohol dependency, TB diagnosis, history of self-harm, a very recent assessment that he lacked mental capacity to make a decision to discharge himself from hospital, the DHR would conclude that the referral to ASC should have been made within multi –agency safeguarding adults procedures, as there was abundant evidence of vulnerability, as defined in No Secrets.

The ASC IMR notes that this referral was a "section 2 notification" which is a requirement (under the Delayed Discharges Act 2004) for hospitals to notify social services before discharging a patient who is likely to need services on discharge. The IMR notes that a worker from their Reablement Discharge Team advised the ward to refer to the Homeless Persons Unit and concluded that there were no issues for social care at this time. The worker made no response to the safeguarding issues.

In summary, the concerns about financial abuse raised by Gustas's friend were not acted upon. Had the hospital made a referral within adult safeguarding procedures, the referral would have been considered by ASC, as a formal adult safeguarding alert and this may have resulted in a more careful assessment of needs and risks.

Similarly, if the Reablement worker had recognised that the subject of the referral was a vulnerable adult and that there was an allegation of financial abuse, they also could have raised a formal safeguarding alert.

As with other points at which safeguarding alerts could have been considered as an appropriate response, it is recognised that any resulting adult safeguarding strategies would very probably not have identified a risk of domestic violence or homicide. The DHR acknowledges an observation made by the IMR author for ASC:

"Though it is tempting for professionals and the media to see safeguarding as the panacea it is seldom able to cure all ills"

On the other hand, this was another missed opportunity for agencies to come together and consider risks and possible risk management approaches.

3.10 Northumberland Tyne and Wear NHS Foundation Trust:

Community mental health and alcohol addiction services

In September 2010 NTW Community Mental Health Team (CMHT) received a vulnerable adult referral from Northumbria Police, following the incident when he had been rescued from the River Tyne. This was re-directed ASC, because the presenting issue was judged to be alcohol dependency rather than mental health. This was not actively followed up by ASC, apart from a telephone call to Gustas following his discharge from hospital, when he advised that he was feeling better (see section 3.4).

In March 2011 Plummer Court received a referral from Gustas's GP, for treatment for alcohol dependency. He attended for an initial appointment for assessment, but subsequently failed to attend several appointments and was discharged in August 2011.

A further referral for alcohol dependency treatment was received from the RVI in February 2012. The IMR shows that from February 12 until October 2012, Plummer Court worked with Gustas, offering a range of interventions to try and help him address his alcohol dependency. The IMR also shows that, over this period, Plummer Court clinicians worked in close liaison with the specialist TB nurses. In addition to clinical interventions, attempts were made to address social issues, including benefits claims and housing needs.

With support from Plummer Court, Gustas reportedly achieved some limited periods of abstinence from alcohol, but with frequent relapses. Following a number of missed appointments in September, a decision was taken to formally discharge him from the addictions service. On 8 October, 2012, the decision to discharge was discussed with the Trust's Safeguarding Team, for advice on whether there were any concerns with the decision to discharge. The IMR outlines that the primary reason for seeking the Safeguarding Team's views was concern about his TB status and possible public health concerns.

The advice from the safeguarding team was that this was a clinical decision for the addictions service and no issues were raised. Both the GP and the specialist TB team at the RVI were formally advised of the decision to discharge Gustas from the Plummer Court.

Analysis

Referral to CMHT, redirected to ASC:
See section 3.4. on ASC. involvement.

Referrals to Plummer Court:
Gustas's vulnerability stemmed, to a very large extent, from his alcohol dependency. This was recognised by NHS primary and secondary health care services, resulting in referrals to Plummer Court. That he was given this opportunity of specialist help with his alcohol addiction is evidence of good communication and joint working between different elements of NHS provision. It was very unfortunate that he was unable to stay engaged with the treatment programme, as overcoming his alcohol dependency would have greatly reduced risks, including self-harm, self-neglect and victimisation from others. It would almost certainly have had major additional benefits for his physical and mental health and compliance with TB medication.

Discharge from Plummer Court:
The decision to discharge him from Plummer Court was discussed with the Trust's Safeguarding Team, which indicates that clinicians had significant concerns. However, the IMR clarifies that these concerns were not in relation any known risks of abuse, but were focused on his continuing alcohol dependency and TB status. On this basis it was not unreasonable to decide that the discharge should go ahead, as he was not engaging with the service. This decision was appropriately communicated to the other organisations involved in his support and treatment.

15/01/2014 FINAL

4) OVERVIEW OF EVENTS AND MULTI-AGENCY RESPONSES:

4.1 Gustas

Gustas was in his early 20s and was a recent immigrant from Eastern Europe. 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, who died of cancer just a few weeks before he was killed by his nephew.

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 behaviours. 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 other 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. Given all of these factors, Gustas was clearly at high risk of coming to serious harm.

4.2 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 services had prior access to information indicating that he was at risk from violent behaviour by Lukas, or any 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 his nephew. 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 Gustas's sister and 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.

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

4.4 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 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 that 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

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.

5) KEY LEARNING

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

5.1 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, Youth Offending Service, courts).

Gustas had high levels of contact with a range of NHS services. He also had contact with ASC 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.

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.

5.2 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 ASC 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 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 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.

5.3 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.

5.4 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 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.

5.5. 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.

5.6 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 assessment. Having said this, it is noted that Lucas'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 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 adult 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.

5.7 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.

5.8 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

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

5.9 Was there any information offered by informal networks?

Gustas's informal networks appear to have been mainly other 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.

5.10 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 Service was involved with the wider family, who were given additional priority for council housing as a result of Ms. B'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.

5.11 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 on the involvement of DWP. Systems weaknesses at DWP meant that he spent long periods with no income, followed sudden influxes of money when back dated claims were processed. This was a significant factor which contributed to his vulnerability.

6) 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 improving local practice and are not specifically targeted at addressing domestic violence issues. For these reasons, 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.

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

- 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

7) 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
Youth Offending 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, which 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 for Work and Pensions	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[4], drawing on the findings from the IMR and the recent Home Office publication "DHRs Common Themes Identified and Lessons Learned"[5]

[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**

15/01/2014 FINAL

SAFER NORTH TYNESIDE

DOMESTIC HOMICIDE REVIEW – (DHR1)13

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. Following the above action, to request a meeting with all six Youth Offending Services with a representative	YOS	Understanding of the scale of the impact of not receiving information via PENY for those aged 18 supervised by the YOS To open the discussion with Northumbria Police as to the opportunities to consider amendments to the current PENY	April 2014 May 2014	Analysis took place on the 6 February 2014. The outcome identified that the six Northumbria YOS were managing approximately 25 18 year olds. The meeting with the Northumbria YOS took place on the 6 February 2014 and had a representative from Northumbria Police present.

Recommendation	Scope of Recommendation	Action to Take	Lead Agency	Key Milestones achieved in enacting the recommendation	Target Date	Date of Completion and Outcome
		from Northumbria Police		operating process.		Discussion took place 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

Recommendation	Scope of Recommendation	Action to Take	Lead Agency	Key Milestones achieved in enacting the recommendation	Target Date	Date of Completion and Outcome
						intranet) to the Instructional 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[6], drawing on the findings from the IMR and the recent Home Office publication "DHRs Common Themes Identified	Local	Domestic Abuse (DA) Coordinator to review domestic abuse training to: • Be aware of recommendations from National and Local DHR's; • Clarify the links between Domestic Abuse	Children, Young People and Learning	Adult Social Care (ASC) training scheduled Local Safeguarding Children Board (LSCB) training	June, 2014 October 2014 February 2015 May, 2014 July,	ASC I 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 12th June 2014. LSCB 1 day DA course updated as above, and timetabled for 4 times

[6] 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**

Recommendation	Scope of Recommendation	Action to Take	Lead Agency	Key Milestones achieved in enacting the recommendation	Target Date	Date of Completion and Outcome
and Lessons Learned"[7]		(DA) and complex needs (including Mental health, Dementia and Substance misuse).		scheduled	2014 November 2014 March, 2015	a year.
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	North Tyneside	Agree a joint strategy for alcohol services with health, public health	North Tyneside Council – Public Health	Joint strategy agreed. Increased variety of service options.	April 2014 Sept 2015	The Alcohol Strategy has been developed, which includes provision for people with complex needs.

[7] "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**

Recommendation	Scope of Recommendation	Action to Take	Lead Agency	Key Milestones achieved in enacting the recommendation	Target Date	Date of Completion and Outcome
Social Care will develop a joint strategy aimed at improving access to a range of services for people with alcohol dependency and chaotic lifestyles, which may not be ready to engage with formal recovery treatment programmes.		and Adult Social Care to maximise resources and expertise.		Improved treatment completion rates. Reduced alcohol related hospital admissions.	April 2015 April 2015	The Strategy is out for consultation which ends the 4 August 2014. A key action of the 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	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.

Recommendation	Scope of Recommendation	Action to Take	Lead Agency	Key Milestones achieved in enacting the recommendation	Target Date	Date of Completion and Outcome
				individuals measured via client feedback.		
Department of Work and Pensions						
Develop protocols to improve liaison/multi agency work with other agencies to ensure those with complex needs are effectively supported	Local, but with a view to sharing good practice nationally	Identify key stakeholders. Arrange meeting to explore issues/develop protocol. Implement protocol Review protocol	Department of Work and Pensions			DWP will be developing their action from July 2014

Appendix 2

List of Abbreviations

A&E	Accident and Emergency
ACN	Adult Concern Notification
ASC	Adult Social Care
CAMH	Child Adolescent Mental Health
CAMHS	Child Adolescent Mental Health Service
CCG	Clinical Commissioning Group
CMHT	Community Mental Health Team
CPN	Community Psychiatric Nurse
DHR	Domestic Homicide Review
DOH	Department of Health
ESA	Employment Support Allowance
ESCR	Electronic Social Care Record
ESL	English as a Second Language
FACE	Core assessment and outcomes package for health and social care
FACS	Fair Access to Care Service
GP	General Practitioner
HAO	Housing Advice Officer
HPA	Health Protection Agency
HTR	Habitual Residency Test
IMR	Individual Management Review
JSA	Job Seekers Allowance
LACE	Risk Assessment Tool
MCA	Mental Capacity Act
MDT	Multi Disciplinary Team

MDTB	Multi Disciplinary Tuberculosis
NICE	National Institute for Health and Clinical Excellence
NHS	National Health Service
POVA	Protection of Vulnerable Adult
RTR	Right to Reside
RVI	Royal Victoria Infirmary
TB	Tuberculosis
UK	United Kingdom
WAO	Welfare Advice Officer
YOS	Youth Offending Service