DOMESTIC HOMICIDE REVIEW

OVERVIEW REPORT

REPORT INTO THE DEATH OF MALE ADULT A

Report produced by the Dorset Safeguarding Adults Board on behalf of the Dorset Community Safety Partnership

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1. INTRODUCTION

1.1 This report of a domestic homicide review examines agency responses and support given to A, prior to the point of his death on 14 April 2011. The review considers agency contact and involvement with A from 01/06/2001 to 14/04/2011.

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

1.3 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.

2. TIMESCALES AND METHODOLOGY

2.1 This review began on 23 June 2011 and was concluded on 14 December 2011. The Independent Management Reviews (IMRs) were completed by 15 August 2011 and the Overview Report was completed within six months of the commencement of the review.

2.2 The author of the report has had access to the combined chronology and the IMRs produced by Dorset Police and Dorset Probation Trust (in the form of a Serious Further Offence report) and had discussions with panel members.

2.3 Reference has also been made to relevant research material about domestic violence and its impact on families.

3. DISSEMINATION

3.1 Copies of this report have been received by the following agencies:

- Dorset Community Safety Partnership
- Dorset Police
- Dorset Probation Trust Board
- Probation Trust from previous area
- Safeguarding Children Board from previous area

4. BACKGROUND

4.1 This review was commissioned following the unexpected death of A on 14 April 2011 and the arrest of his son B who was charged with his murder. B admitted manslaughter through diminished responsibility and was convicted on 13th August 2012. The prosecution accepted his plea after doctors confirmed that B was mentally ill. On 3rd January 2013, B was given a Section 37 hospital order under the Mental Health Act 1983 and a Section 41 restriction under the same act, with the latter being for “the protection of the public from the risk of serious harm B presents”. The sentence is indeterminate and B will only be released if he is assessed as no longer being a risk to the public.

4.2 It was agreed by the CSP that this case met the requirements for undertaking a Domestic Homicide Review.

4.3 The Dorset Community Safety Partnership (CSP) commissioned the Dorset Safeguarding Adults Board to undertake the review on their behalf. The review was later endorsed through the Dorset CSP in accordance with the agreed process and to ensure compliance with national guidance.

5. TERMS OF REFERENCE AND METHODOLOGY

Time Parameters for Review

5.1 Each agency to review:

- family tree known to agency
- chronology of events
- intelligence known to agency
- decisions reached and actions taken in relation to their involvement with A and B and other family members (if relevant to domestic violence) between 1 June 2001- 16 April 2011.

5.2 Analysis of involvement to cover the following:

- Application of individual agency Policy and Procedures, Multi Agency Policy and Procedures and legislation;
- Were practitioners sensitive to the needs of victim and the perpetrator; did practitioners have adequate training, knowledge and experience?
- How accessible were services for the victim and the perpetrator?
- Did the agency utilise risk assessments, if so were they correctly used?
- Was the victim subject to DASH Risk Identification Checklist and Multi Agency Risk Assessment Conference?
- Were decisions reached and informed in a professional way?
- Did action/risk management plans fit with the assessment and decisions made?
- When and in what way were the victim’s wishes and feelings ascertained and considered? Was the victim signposted to other agencies?
- Analysis of the victim/perpetrator relationship and management plans for perpetrator (Multi-Agency Public Protection Arrangements/Serial Perpetrator of Violence);

- Was the information known to the agency recorded and shared where appropriate? Particular reference to be made to the transfer of information across service and geographical boundaries (i.e. Youth Offending Team - Probation, Children's Services to Adults', Previous authorities to Dorset authorities);
- Were procedures sensitive to ethnic, cultural and religious identity of victim, perpetrator and their families? Was consideration in respect of vulnerability and disability necessary?
- Were managers involved at the appropriate points?
- Was any good practice identified that can be passed on to other agencies?
- What practices can be improved on and lessons learnt?
- To what degree could the homicide have been accurately predicted and prevented?

Involvement of Family Members

5.3 The next of kin is the ex-wife of A and the mother of B. She is likely to be a defence witness and therefore cannot be involved in this review until after the court case has concluded. The brothers of B are prosecution witnesses and also cannot be involved until after the criminal proceedings.

Involvement of Other Organisations (other than DSAB)

5.4 The involvement of other organisations included those involved in the

- On-going criminal investigation
- On-going Coroner's investigation
- On-going Serious Further Offence Review by Dorset Probation Trust

Commissioning of Independent Overview Author

5.5 An independent author with relevant knowledge and experience was commissioned via the Dorset Safeguarding Adults Board.The Independent Overview Author was required to conduct the review in accordance with the agreed framework set out by the Home Office in the 'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews.'

Legal Advice

5.6 Legal advice has been taken in relation to the court process and disclosure issues.

Expert Opinion

5.7 None taken at this time.

5.8 Media and Communications

No internal communications or external communications will be published until after the criminal proceedings. Updates to the Community Safety Partnership will be completed; however, they will not be discussed in an open forum until after the criminal proceedings.

Liaison with Home Office

5.9 Completed on the 21April 2011 by Dorset Police.

Structure of IMR

5.10

- Introduction (TOR, brief summary, identification of persons subject to review, date of birth, date of death) Name and job title of IMR author and confirmation of independence from line management of the case
- Family tree or genogram if relevant (name, date of birth, relationship, ethnicity and address)
- Terms of Reference given to IMR author and methodology used to complete the IMR
- Details of parallel reviews/processes
- Chronology of agency involvement
- Analysis of involvement
- Effective practice and lessons learnt
- Recommendations

Contributors to the Review

5.11 The following agencies contributed to the Review:

- Dorset Police – provided records of their contact with A and B from 3 April 2009 to 15 April 2011and also records received from another Police Service where the family resided covering the period from 29 October 2000 to 1 February 2009.
- Dorset Probation Trust – provided information regarding their contact with B during the period from October 2009 to 31 March 2011. B was subject

to an 18 month Community Order with supervision imposed in March 2010. This order was revoked on 31 March 2011 two weeks prior to A's death. As a result Dorset Probation Trust was required to complete a Serious Further Offence report and this report was made available to the DHR Panel.

- Although not formally contributing to the review some historical information was sought and obtained from agencies in the area where the perpetrator had lived as a child with both his parents; notably the Probation Trust, Police and Children's Services.

5.12 DHR Panel members included

- Independent Chair Dorset Safeguarding Adults Board
- Detective Superintendent Dorset Police
- Director of Public Protection and Offender Management Dorset Probation Trust
- Service Manager Safeguarding AdultsDorsetCounty Council
- Domestic Violence Strategic Co-ordinatorDorset County Council

6. THE FACTS

Circumstances of the Murder

6.1 A lived with his son B. On 14 April 2011 Police were called by a neighbour to attend the family home, where on arrival they located A's dead body. He had died as a result of numerous injuries to the head. The police arrested B on suspicion of his murder.

Members of the Family and Household

6.2 A had lived in Dorset since about 2004. He moved to Dorset to care for his elderly father, and remained in Dorset after his father's death. He separated from his wife in 1992 and they divorced in 1994. They had three sons. The children continued to live with their mother after the divorce. It is estimated that B had moved from this home to live with his father between February and April 2009 and he continued to live there for two years until his father's death in April 2011. B had also previously lived for a short time with his father between 2001 and 2002. B's brothers, C and D had visited their father in Dorset. C had lived with him and B briefly in April and May 2009 and D had also lived with them from approximately

July to December 2010.

Chronology

6.3 The chronology shows a significant amount of historic contact with the family from the Police due to domestic violence. There are reports of violence from A towards both his wife and his children dating back to 1998. The chronology also shows increasing numbers of incidents where the children are becoming out of control and engaged in criminal activity. Following B's move to Dorset in 2009 there were also incidents involving Dorset Police and B was subject to supervision from Dorset Probation Trust for eighteen months. The relevant facts in relation to B and his father A are summarised below.

6.4 Summary of Agency Contact

6.4.1 Information from the IMRs submitted by Dorset Probation Trust and Dorset Police show that B experienced a difficult childhood as part of a dysfunctional family. Both his parents had alcohol abuse problems, and B was more than once assaulted by his father. B witnessed domestic abuse of his mother by his father who left the family home when he was young. As a result of his mother's alcohol misuse, it is reported that he and his brothers received very little in the way of guidance and boundary setting and the police reports show B becoming increasingly out of control. By the time B reached the age of thirteen, his mother was unable to care for him and B moved in with his father in 2001.This arrangement did not last long and B later reported to his Offending Manager that his father's alcohol abuse was the main factor in this situation breaking down. In January 2002 B (then aged fourteen) reported to school that his father had hit him with a belt resulting in cuts to his arm. At this time B was on bail for robbery and due to his behavioural problems he was moved to a children's home. He refused to make a formal complaint about the incident.

6.4.2 A summarised sample of information from Police during the period when B lived at home in a previous location illustrates the context of his behaviour:

- October 2000: Police are called to the family home as C has smashed the rear window of his mother's car and run off. B has threatened his mother with a knife after a dispute. His mother is drunk. Police attend and remove the youngest son D and take him to the home of his estranged father A;

- Early 2003: Reports of numerous domestic violence incidents between B's

mother and her new partner.B's mother is now pregnant;

- Early 2003: During a pre-arranged visit by B to see his father, his father throws him across the room, breaking the plaster cast on his already broken arm. A is apparently drunk and B is winding him up. B does not wish to see his father and does not wish to make a complaint of crime against him;

- May 2003: Police attend A's mothers address following a report of domestic violence. The police report describes 'numerous episodes of domestic violence involving the mother, her ex husband A and her current partner. Current offspring B had expressed concerns of harming the baby when born'.

6.4.3 B left school early and struggled with literacy. He had several assessments with regard to learning difficulties, but there is no record of any formal diagnosis, although he did attend a special school for a period. As a child he underwent psychological assessments although he was never treated for mental illness, but he described receiving medication when he was young to help him to manage his anger.

6.4.4 B lived in a number of different local authority placements such as children's homes until he was sixteen when he was further supported by the social services leaving care team. During this period there were numerous reports of B being reported missing and returning to his mother's home and also that he was suicidal, subject to self harm and a cannabis user. There was also an increase in his criminal behaviour. In June 2005 there was an episode when together with another youth B robbed a young man at knifepoint, and in the same month the police received intelligence that B had assaulted a deaf male. In May the following year a thirteen year old male reported that while attending special school he was raped by B but there was no prosecution. B also spent time in prison, serving a two year sentence for burglary from which he was released to a bail hostel in November 2007.

6.4.5 B maintained some level of contact with his mother, brothers and grandparents although there was on-going conflict as a result of his behavioural issues. In June 2008, there was an allegation that he had sexually abused a five year old girl. B denied the offence and the CPS declined to prosecute him. In July 2008 he returned to his mother's home and a domestic dispute occurred where he threatened to smash her windows. He was arrested and convicted and his grandparents withdrew their support at this time.

6.4.6 B moved to Dorset to live with his father in early 2009. There are no records of the specific reason for this although from later records an assumption can be made that B felt unwelcome where he had been living and his father was willing to

support him. The chronology summarised below records information from Dorset Police from the period from April 2009 to March 2010.

6.4.7 Following B's move to Dorset in 2009 a summarised sample of information from Dorset Police records includes the following:

- 3 April 2009 at 4.00am: A's sons B and D have stolen and crashed his car. Both are arrested. B is sentenced to six months conditional discharge, and his brother is sent to a Young Offender's Institution for eight weeks;
- 2 May 2009 at 1.05am: D reports that B has assaulted him. It transpires D was released from prison that day and both brothers had been drinking. The circumstances reported were that after returning home D found a reference on Facebook to B being a paedophile and mentions this to B who attacks him. B is arrested and claims self defence. Their father A is interviewed and states he had to pull them apart, stating that 'they are just as bad as each other'. B is released without charge;
- 6 October 2009: Dorset police officers arrest B for a 'failure to appear' warrant issued by a Magistrates Court on 30 March 2009 and he is returned to the area. B is in breach of a Community Order and is sentenced to a further Community Order for six months with supervision. The Order is transferred to Dorset Probation Trust;
- 14 December 2009 at 6.30 pm:B reports to police that he has been assaulted by his father who has punched him in the face. A is arrested for assault. A states his son was in a rage and damaging his wardrobe and he was calming him down. CPS decline to prosecute A. At 10.05pm A returns home believing that B is absent. At 11.15pm A calls the police reporting that B is assaulting him with an iron bar. B is arrested for attempted murder but subsequently charged with wounding with intent and affray and remanded by the court to prison. Police records show that this was a serious and sustained assault with B threatening to kill A;
- Whilst B was on remand in prison following the assault on 14 December, he received a letter from his father who gave permission forB and his defence to use this in court. In this letter A describes his son as aggressive and a provocative drunken person, but also acknowledges the poor home circumstances provided to his children 'from 1993 in which drunkenness and violence were the norm (and) there was little supervision or discipline' and states that he totally mishandled B and 'his frustration reached a head' and that he reported the second incident to police for fear of hurting B and getting into further trouble. As a consequence of this letter, the defence wrote to the CPS and offered a plea of guilty to Actual Bodily Harm (ABH).

As A was refusing to give evidence, the CPS accepted this plea;

- 12 March 2010: B appears in Court and pleads guilty to ABH and Affray and is sentenced to a community order for eighteen months with a supervision requirement, and is released from custody;
- The police have no further contact with either B or A until 14 April 2011 when they are called to A's home and find his dead body.

6.4.8 Dorset Probation Trust assessed B both prior to sentencing and subsequently under their regular Offender Assessment System (OASys) process. The initial report identified accommodation, alcohol, thinking and behaviour as problem areas, and the OASys assessment scored a number of criminogenic need areas 'above the line'. These assessments were used to determine the Sentence Plan objectives.

6.4.9 The initial focus was on two areas. The first was with the suitability of B's accommodation, which was due to his returning to live with the victim of his current offence. He also accused his father of bullying him on a regular basis and attributed the index offence to the consequences of this. However A reported that there were no options for alternative accommodation within the family and he 'had no concerns whatsoever in relation to B returning home'. The second area was with education/training/employment (ETE). B struggled with literacy and had not undertaken any form of employment but had undertaken some training with the job centre. There was also a sentence plan objective to increase the understanding of likely consequences for self or others of offending. This was to be measured by feedback in supervision and lack of further offending.

6.4.10 There were nineteen further formal appointments (including one home visit) with Dorset Probation Trust Offender Managers (OMs) between 1 April 2010 and 31 March 2011 when the Community Order was revoked at Crown Court and the case was terminated. There were also a number of other contacts, mainly by telephone during this period. The following contacts are of particular note:

- 25 March 2010 B leaves a message on the OM's answering machine stating that 'there has been a bit of bother at my Dad's, the best thing I am going to have to do is move to Leeds'. The OM responds to this call on 29 March and is told by B that he does not now want to move to Leeds. A home visit is made on 1 April but this issue is not discussed;
- 29 April 2010 The OM telephones B to advise him that the reporting requirement has now been reduced to fortnightly due to his Tier 2 status;

- 21 May 2010 B reports that he is ‘staying in too much’;
- 11 June 2010 B reports that he is drinking to excess ‘but only at home’;
- 18 June 2010 B attends without an appointment and reports ‘some strains at home’;
- 22 June 2010 B telephones stating that over the weekend he and his father had been arguing and had once come to blows. Both had been drinking and he is worried he might lose his accommodation. The OM advises him to contact the Local Authority Housing Department and also records that things ‘are not yet at crisis point’. Housing Services have no records relating to A or B so it is concluded B did not act on this advice
- 29 November 2010 Telephone call to The OM from A who reports ‘having difficulty with offender and issues with his drinking since his brother (C) has been residing in the home’;
- 30 November 2010 B reports that he is ‘unhappy and bored’ since losing his employment;
- 19 January 2011 B reports that there are problems with his father’s drinking but denies any issues with his own drinking;
- 16 February 2011 B reports that if his father has had a drink he keeps out of his way and as long as they are not in the same room when he is drinking there is not a problem.

6.4.11 On 3 March 2011 the OM made a request for early revocation of the Community Order for good progress. This request was not signed off by the Unit Manager which is usual practice but was signed off directly by the Assistant Chief Officer (who assumed it had been signed off by the Unit Manager) and forwarded to the Court. The application was granted at Crown Court on 31 March 2011, two weeks before B killed his father.

6.4.12 The Serious Further Offence Review Document completed by Dorset Probation Trust has highlighted some poor practice in the management of this case which will be addressed in the Analysis section below.

7. ANALYSIS

7.1 The information summarised in this report begs a number of questions, principally in relation to decisions made regarding the risks involved in B returning to live with

his father following the serious nature of the incident on 14 December 2009, and the adequacy of the supervision and support that both he and his father received during the period between December 2009 and his father's death in April 2011. There are also more general questions about the lack of knowledge and recognition across agencies of domestic violence or inter-familial violence between people of the same gender who are not partners, and how to properly respond to this. There appears to be little research into this area other than research which looks at the impact of domestic violence on children referred to in paragraph 6 below. Finally there were issues about lack of access to historical data by Dorset Police and Dorset Probation Trust.

7.2 The family history outlined in this report paints a picture of B as a young man with limited life skills and borderline learning difficulties who grew up in a family where both his parents drank heavily and there were frequent episodes of domestic violence. B regularly suffered abuse and was subject to neglect. His early engagement in criminal activity is not be condoned but is perhaps not surprising and is in line with research into the impact on children of growing up in a violent family (see paragraph 7.6). He appeared to have little contact with his father except when his own behaviour made it impossible for him to remain in his mother's home. Their relationship was volatile and there were reports of his father's violence towards him during the periods when they lived together. At the same time B was also prone to violence. He appeared to have difficulties with anger management, often triggered by alcohol, and this increased the risks for him in living with his father who drank heavily which increased his own propensity to violence. This is illustrated by the evidence both from the police reports and from the reports that B and A made to the OM on 22 June 2010 and 29 November 2010. Overall this was a scenario which appeared to pose significant risks for both B and A.

7.3 Dorset Probation Trust have been rigorous in their analysis of their agency's responsibilities and actions in relation to the supervision of B. Both of the Offender Managers involved had over 10 years experience and had undertaken the available domestic violence training. Dorset Probation Trust have identified a number of areas of poor practice in this case as follows:

- The Fast Delivery Pre-Sentence Report completed by the OM prior to B's court appearance in March 2010 did not include the Affray offence which might have triggered a dangerousness assessment had it been included. In any event the circumstances of the offence and the knowledge that the offender was returning home to live with the victim should have resulted in a thorough assessment and

potentially a re-tiering of the case at that stage;

- There was no record of a referral for alcohol assessment after meeting B on 25 March 2010 when he acknowledged that his offences were alcohol related, nor any action to refer him to a treatment provider for assessment of his level of alcohol use following the report of the incident involving drinking on 22 June 2010, even though this would have been easy to arrange as the meetings with B often took place at the premises of the alcohol treatment provider;

- There was a lack of adequate sentence plan objectives in the Initial Sentence Plan which was completed on 29 March 2010, to address the areas of criminogenic need which scored above the line in the OASys assessment;

- There was poor risk management and inadequate actions taken to reduce risk, including insufficient detail in the initial Risk Management Plan and a lack of actions to assess or manage risk as follows:

I. There was no record of a discussion regarding risk issues following the message B left on the OM's answer-phone on 25 March 2010 saying there had been 'a bit of bother at my Dad's, the best thing I am going to have to do is move to Leeds';

II. There was also no discussion about risk factors in the three meetings with B in April 2010 and no regular home visits undertaken to manage the risk as had been proposed in the Pre-Sentence Report;

III. There was no action taken in relation to primary risk indicators such as reports of 'drinking to excess' (on 11 June 2010) and failure to follow up reports from B of 'some strains at home' (on 18 June 2010) and reports that he had been 'arguing with his father and had once come to blows' when both had been drinking (on 22 June 2010);

IV. Dorset Probation Trust has recorded that they would have expected actions recorded to assess or manage risk and arrangement of a home visit in such circumstances. There was particular concern about the latter incident, which signified increasing risk, but no consideration was given to revising the risk to A from medium to high and the police were not informed. The advice regarding contacting the housing department on 22

June 2010 was also felt to be inappropriate given the level of risk, and if the risk level had been revised at this point then plans could have been made to secure alternative emergency accommodation in Approved Premises if needed;

V. The assessment by the OM on 22 June 2010 that things had not reached crisis point was based on information provided by the perpetrator (B) only and no efforts were made to seek supporting information by arranging an immediate home visit to discuss matters with both B and A ;

VI. At no stage throughout the supervision was the risk re-assessed as high, so no consideration was made by the Offender Managers to refer the case to MARAC

VII. The reporting frequency was rescheduled from weekly to two-weekly on 29 April 2010, but there was no information giving the reasoning for reduced reporting requirements, such as a reduction in the risk assessment or completion of the sentence plan objectives, nor any evidence of a case discussion with the Unit Manager ;

- Although discussions were recorded with B on 7 May 2010 regarding his education, training and employment options, including his problem with dyslexia, there was no evidence of any referrals made in either the file or the contact log, although lack of employment was a risk factor given the increased time B would be spending in the family home with his father;
- In July 2010 B advised that his brother C was planning to relocate to Dorset. The potential impact of this was not fully assessed either through discussions with B and his father or through a home visit;
- Review 3 completed on 10 September 2010 was not updated in respect of the alcohol and relationship sections;
- On 29 November 2010 A telephoned to report that he was having difficulties with B and issues with his drinking since his brother had been residing at home. No home visit was arranged to assess both the risk and the current situation and no contact was made with the police to provide an updated risk assessment. On the following day when the OM met with B he recorded that he felt unable to fully discuss B's father's concerns due to possible conflict between the two – as a result no action was taken to assess the risk factors;

- On 19 January 2011 B reported that there were problems with his father's drinking. The OM did not appropriately prioritise this as a risk factor and decided to focus on the ETE and transport issues in his discussions with B.

7.4 The Dorset Police analysis makes the following relevant points:

- A was reported to start drinking at lunchtime and ending up either happy or argumentative. B also liked a drink and if he drank more than two pints he became difficult. The routine was for B to have a drink after his father had gone to bed, to avoid them both being in drink at the same time, which would end in argument;

- In relation to the dispute between A and B on 14 December 2009, when the police initially arrested A following a complaint from B that his father had assaulted him, it is easy to see the incident other than described by A at the time (as having accidentally 'elbowed' B while trying to control his rage). The record states that it is equally likely that A having consumed alcohol lost his temper with B and did punch him in the face, but the truth will never be known. The police officer identified that this was a Domestic Violence (DV) incident and that the risk of further violence was medium;

- Following the allegation of assault, there was at the time no reason to believe that B would hide in the house and attack A, and it was felt by the police that B was the person at risk and not A. However B did attack A and this was a serious and sustained assault with an iron bar, and B spoke of his intention of killing A. This incident was also identified by the police as a DV incident and the risk was assessed as high, but the risk was countered by B being remanded to prison. On submission of the DV form and risk assessment the case would have been considered for its suitability for referral to the Multi Agency Risk Assessment Conference (MARAC), but it was not suitable for referral because 1) the threshold for referral is 'very high risk' and this case was graded as 'high risk'. 8 of the criteria for determining risk were identified 14 criteria would have been needed to be graded as "very high risk" and 2) B had been remanded to prison which countered the risk to his father;

- Whilst in prison B wrote an apologetic letter to his father who responded with the letter described in paragraph 6.4.7 of the Summary of Agency Contact, making it clear that he was happy for B to return home;

- Following the release of B from prison in March 2010, the Dorset Police Domestic Violence team did not become involved with this family as might have been usual in a situation where the victim of domestic violence was at risk of further violence. However the offender in this case was moving back in with the victim A who had written to B while he was in prison stating that he had forgiven his son and he was welcome home. In retrospect if this had been a 'classic' case of domestic violence, involving a male and female partner, then the risks might have been assessed differently;
- During the two year period B and A lived together Dorset Police were only aware of the one incident (on 14 December 2009) of domestic violence between father and son prior to the murder. This involved both an assault by father on son and a subsequent, more serious assault by son on father, with the exact reasons for these assaults being unknown.
- In short the involvement of Dorset Police with A and B although important, was limited.

7.5 There is a very real question about whether different actions in this case could have led to a different course of events. B's history was well known to another Police Service but this detail was not known to Dorset Police until after the event, as police records are not transferred between areas when individuals move. In this case Dorset Probation Trust had the best overview of B's life, including the violence and neglect he had suffered as a child, although their information was also not complete, particularly in respect of the early multi-agency involvement in the family, and B's youth offending history. In respect of the Dorset Probation Trust involvement, warning signs were either missed or not acted on and risks were consistently not properly assessed or given enough weight. Dorset Probation Trust did not view this case as a domestic violence case and OM confirmed that he felt the risks to B were more significant than those to his father, but despite this there were no domestic violence checks made with the police or the previous OM. There was acknowledgement that the risks were assessed differently as a result of the victim being male and the perpetrator being his sonand the OM made assumptions about the victim's ability to protect himself. If the case had been viewed as domestic violencethis might have led to a different prioritisation in relation to identified risks.

7.6 Research into the impact of children living in a violent family also shows the significant affect of domestic violenceon them. Although domestic violence is seen more commonly as an issue between intimatepartners, with the majority of

domestic violence perpetrators being men who abuse female partners, it is worth noting that research shows that children in a violent family 'experience fear and distress as well as varying degrees of physical, psychological or emotional development problems' (CSI Research Briefing 25 June 2008). In summary, this includes a danger that they will learn aggression, and it will become part of their pattern of behaviour. Children who have been abused often have intense negative feelings about their parents and their behaviour but contradicting these feelings are feelings of love and identification with them. Children may take either the learned abuser or victim role as an adult. Generally a male child will initially identify with the mother and have intense negative feelings towards the father, and as he reaches adolescence he may become violent, rebellious, and out of control. He may then begin to identify with the father and he may also begin to drink to excess, damage property, and behave violently towards younger siblings. This profile appears to fit B closely and illustrates the increased risk to him and his father of them living together. B, his brothers and his mother had been subject to regular violence from A both during the marriage and after A and his wife separated. Records show that B became out of control and involved in criminal behaviour at an early age, but that he was also vulnerable in terms of his borderline learning difficulties and limited life skills.

7.7 Apart from B's assault on his father on 14 December 2010 there is no record of other criminal activity from February 2009 to April 2011 apart from the two incidents involving his brother D in 2009, firstly in April when they stole and crashed their father's car, and then in May when the two of them got into a fight. There were no recorded incidents of criminal activity outside the family during this period which shows an improvement in B's ability to refrain from general criminal behaviour. This is substantiated by the initial OASys assessment carried out by Dorset Probation Trust which records 'despite being involved in criminal activity from a young age (B) does not appear to support it as an acceptable way of life. When younger many of his friends were involved in crime and it appears that he was easily influenced.'

7.8 Another issue to be considered is the impact of work pressures within Dorset Probation Trust at this time. At the time that the case was taken on there were some pressures around the OM receiving a high number of cases at once. There was also pressure from within the organisation on OMsto ensure that timeliness targets were met, although the Unit Manager confirmed that this was not expected to compromise the quality of risk assessments. If an assessment had to be locked off to meet targets it should be revisited as a matter of priority and updated. This was not done in this case and it was reported by the OM that this was due to the case being rated at Tier 2, and his having competing priorities from other high priority Tier 3 and 4 cases. This is an organisational issue for Dorset Probation Trust regarding resources, particularly regarding the capacity of OMs to work with

too many higher tier cases and whether cases are tiered based on capacity rather than risk. This view is not supported by Dorset Probation Trust and is addressed in their action plan at the end of this report.

7.9 There have been some examples of good practice identified as a result of this case. Dorset Police correctly identified the case as a domestic violence case and considered whether B was eligible to be considered for referral to MARAC in December 2009 following his assault on his father. Dorset Probation Trust noted that when B was referred for assessment following the offence of December 2009, this was appropriately allocated to his current Offender manager.

8. CONCLUSIONS

8.1 There are many lessons to be learned from this Review, particularly in relation to the importance of sufficient and appropriate risk assessment and risk management, and the need to ensure effective communication across agencies, including agreement about when to recognise cases as meeting the definition of domestic abuse. There are also wider questions about access to and transfer of historical information across geographical areas which might have made a difference in this case.

8.2 This case was not the most common type of domestic violence case as it involved a father and son, both of whom were either the perpetrator or the victim at different times. Dorset Police and Dorset Probation Trust had both identified B the son as being most at risk and more of the victim in this scenario, and his history showed him to be vulnerable with limited intelligence and life skills. This does not condone the fact that in the end he was responsible for the death of his father, but it does give some context for his actions.

8.3 The evidence from this review shows that opportunities to reduce the risk to both father and son in this case were not taken, in particular in relation to the risk of B living with his father. There were a number of signals that should have raised concern and led to a more decisive response from Dorset Probation Trust, particularly in June and November 2010. This should have led to a reconsideration of the risk assessment and the re-tiering of the case and the closer involvement of other agencies such as Dorset Police, and possible referral to MARAC which would have brought with it referral to the Independent Domestic Violence Advisor (IDVA) service. More concerted action to secure alternative accommodation for B and to more actively support him in developing his opportunities for education, training and employment, and to deal more effectively with his drinking problem and ways of managing his anger, could also have made a significant difference to the outcome.

8.4 Dorset Probation Trust have recognised their own failings in this case and taken appropriate actions to improve their service as a result of the lessons learned and

this is demonstrated in the Recommendations and Action Plan set out below.

8.5 There are also more general lessons to be learned. As set out earlier in this report, there is a lack of recognition nationally regarding the relevance and application of domestic violence policy and procedures where the victim and perpetrators are of the same gender and are not partners. Dorset Probation Trust have acknowledged that their current thorough and mandatory training for staff on Domestic Violence is centred on male/female scenarios (where either gender can be the perpetrator or the victim) and this is likely to be the case across most if not all agencies nationally. There are also issues about better information sharing across and between agencies, particularly when people move to a different area. Dorset Police did not the previous police records from a different area until after A's death. Dorset Probation Trust had more information but in a summarised form which did not give the full picture and level of domestic violence in B's family and the multi-agency involvement, nor of his youth offending history. As a result neither Dorset Police nor Dorset Probation Trust were able to make a full assessment of the risks posed by B and A living together. Finally there is a question about the helpfulness of the current range of overlapping policies and procedures covering domestic violence and abuse, which can lead to confusion or to cases 'dropping through the net' by not meeting specific thresholds or definitions, as happened in this case.

9. RECOMMENDATIONS AND ACTION PLAN

9.1 Recommendations to the Dorset County Domestic Violence Strategy Group (in view of the cross-boundary nature of the work and key agencies it is suggested that the Poole and Bournemouth Domestic Violence Strategy Group is invited to co-work on these recommendations where appropriate)

9.2 Widen views across agencies regarding the understanding of definitions of domestic violence and how current approaches need to be streamlined to enable relevant issues to be taken into the MARAC procedures .

9.3 Using relevant national research into same gender and inter-familial domestic violence agree processes for widening the brief of domestic violence and abuse training to include same gender and inter-familial scenarios and working with relationships where perpetrator and victim are "interchangeable". Police and probation to feed this into their respective training models.

9.4 Police and probation services to work together to develop an enhanced understanding of higher risk and identify trigger factors that will lead to staff carrying out a joint full risk assessment and problem profile and collecting all relevant available historical data.

9.5 Make representations to the Home Office regarding the multiplicity of current procedures and processes for dealing with domestic violence and abuse across agencies and the need for these to be simplified and streamlined particularly the timescales for DHRs when criminal proceedings are underway.