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SAFER CORNWALL

CORNWALL COMMUNITY SAFETY PARTNERSHIP

Domestic Homicide Review 3

Executive Summary of the

Overview Report into the

Death of Mr Mike Smith

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Independent Chair and Overview Report Writer

CONTENT

1 Introduction

1.1 For the purpose of this Domestic Homicide Overview Report and in order to protect the identity[1] of those involved, the victim will be known as Mr Mike Smith, his son as Tony, daughter as Chloe and his former wife as Joyce. The perpetrator will be known as Mr Barnes[2] , his Aunt as Mrs East, his Uncle as Mr Newton and his **[redacted]** as Mr Kay.

1.2 This Domestic Homicide Review (DHR) follows the death of Mr Smith, reported on **[redacted]**. The Police were called to Mr Smith's home where Tony had visited to give Mr Smith his **[redacted]**. Mr Smith was found deceased **[redacted].** A paramedic pronounced life extinct at 10.45pm. Whilst Mr Smith had been unlawfully killed, a post mortem examination conducted by a Home Office Pathologist on **[redacted]**, gave the medical cause of death as 'Unascertained'[3].

1.3 On **[redacted]** Mr Barnes pleaded guilty to Mr Smith's murder and was sentenced to life imprisonment, with a minimum tariff of 15 years set by the Crown Court Trial Judge, who said it was a 'premeditated killing'. Drawing a comparison with a previous offence, involving the false imprisonment[4] of Mr Kay, committed between **[redacted]**, for which he was cautioned[5], Mr Barnes said 'I did what I did but this time he died'. On **[redacted]**, a Coroner's Inquest was held regarding Mr Smith's death. A verdict that Mr Smith had been unlawfully killed was recorded by Her Majesty's Coroner for Cornwall.

2 The Domestic Homicide Review (DHR) Process

2.1 DHR's were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act 2004. They came into force on 13 April 2011 with due Home Office Guidance[6]. The Act requires a 'review of the circumstance in which the death of a person aged 16 years or over has or appears to have, resulted from violence, abuse or neglect by: a person to whom he was related or with whom he was or had been in an intimate personal relationship, or a member of the same household as himself'.

2.2 In compliance with the Home Office Guidance, Devon and Cornwall Police notified the circumstances of Mr Smith's death to The Safer Cornwall

[1] The pseudonyms Mr Mike Smith, Tony, Chloe and Joyce were chosen by the victim's son and the other pseudonyms were chosen by the Independent Chair and Overview Report Writer.

[2] Mr Barnes's parents will be known as Mr and Mrs B. Barnes. They died in **[redacted]** respectively.

[3] Where a pathologist is unable to establish an exact cause of death.

[4] A Common Law offence which can only be tried at a Crown Court. Upon conviction the maximum punishment is a life sentence. This is where a victim is detained against their will.(Blackstone's B.2.74)

[5] This is a formal alternative to a criminal prosecution, administered by the police, normally for low level offending.

[6] Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Revised August 2013).

Partnership (SCP)[7], who commissioned a DHR. There were no other parallel reviews being held, such as an Adult Safeguarding Serious Case Review[8], or Mental Health Homicide Investigation[9].

3 The DHR Panel

3.1 The review was carried out by a DHR Panel which represented a broad spectrum of both statutory and voluntary sector agencies. Representation was at a sufficient level of seniority within their respective organisations to commit to the delivery of resulting recommendations. The DHR Panel members had widespread knowledge and expertise in their specific areas of work.

3.2 The SCP appointed an independent consultant Mike Fowkes, as both Independent Chair and Overview Report Writer. He retired from Devon and Cornwall Police in April 2011, at the rank of Detective Chief Inspector. As a previously nationally accredited Senior Investigating Officer, he was experienced in the investigation of a large number of domestic homicides. He met the skills and experience criteria outlined in the Home Office Guidance. The other members of the DHR Panel and their professional responsibilities were:

- Detective Chief Inspector Public Protection Unit, Devon and Cornwall Police.
- Manager of Domestic Abuse Services and elected representative of Domestic Abuse and Sexual Violence Voluntary Sector Providers.
- Domestic Abuse and Sexual Violence Strategy Manager, Community Safety and Protection, Cornwall Council.
- Adult Safeguarding Lead Professional, Cornwall Partnership NHS Foundation Trust (CFT).
- Senior Probation Officer, National Probation Service (South West & Central).
- Safeguarding Adults Lead, NHS Kernow.
- Safeguarding Adults Co-ordinator, Cornwall Council.
- Assistant Director of Nursing Patient Experience, NHS England.
- Health Promotion Service Manager/Team Member, Health Promotion Service Cornwall & Isles of Scilly ('Healthy Gay Cornwall' is one of its programmes).

[7] Safer Cornwall is the chosen name for the statutory Community Safety Partnership which covers Cornwall. (The Safer Cornwall Partnership). It is a collective of public, private and voluntary sector organisations.

[8] Where an adult with needs for care and support was, or it was suspected was experiencing abuse, or neglect and the adult dies, or there is reasonable cause for concern about how person(s) involved in the adult's case acted.

[9] Where a homicide has been committed by a person who is, or who has been under the care of specialist mental health services in the six months prior to the event; where it is necessary to comply with the Human Rights Act 1998, or where it is deemed an independent investigation is warranted e.g. concern of systemic system failure.

- Senior Manager Professional Practice, Education, Health and Social Care, Cornwall Council.

3.3 The DHR Panel sought additional expertise from an independent LGBT domestic violence and abuse expert[10]. The LGBT expert's contribution has greatly enhanced this DHR. As an academic Professor, heading a leading faculty in Gender-based Violence, the LGBT expert is acknowledged as one of the main experts in the UK and Europe and a leading expert internationally. The LGBT expert was also awarded an OBE for services to the community in tackling domestic abuse.

4 Purpose and Terms of Reference for the DHR

4.1 The Home Office Guidance states the purpose of having a DHR is not to reinvestigate or to apportion blame. It is to:

a) Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
b) Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
c) Apply those lessons to service responses including changes to policies and procedures as appropriate.
d) Prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.
e) Ensure agencies are responding appropriately to victims of domestic violence and abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions, with an aim to avoid future incidents of domestic homicide and violence.
f) Assess whether agencies have sufficient and robust procedures and protocols in place, which were understood and adhered to by their staff.

4.2 The scope of the DHR was carefully considered by the Panel and clear terms of reference drawn up which were proportionate to the nature of Mr Smith's death. The intention of the Panel and its review was to reflect on significant and relevant events leading up to Mr Smith's death and analyse the actions of relevant agencies. It was also to identify whether Mr Smith's death was predictable or preventable and with the purpose of creating a joint strategic Action Plan, to address any gaps and improve policy and procedures in Cornwall and across the South West Peninsula. The DHR was underpinned by the following values and principles:

- Independent, unbiased and objective.
- Openness and transparency, acting in the Public Interest.
- Sensitivity.

[10] Herewith referred to in the Executive Summary as the LGBT expert.

- Thoroughness and Meticulous.
- Challenging and deliver change.

4.3 The DHR Chair sought to instil an open and honest approach with a willingness to challenge robustly the actions, or lack of them, of the relevant organisations. This required a high level of organisational self-awareness and a critical, but supportive and respectful approach.

4.4 The detailed terms of reference of the DHR, as agreed by the Panel, following consultation with members of the SCP and Mr Smith's family, were as follows:

- Ensure the review is conducted according to best practice, with effective analysis and conclusions of the information related to the case.
- Establish the facts that led to the events reported on **[redacted]** and what lessons are to be learned from the case regarding the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence and abuse.
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted upon, and what is expected to change as a result.
- Apply those lessons to service responses, including changes to policies procedures as appropriate.
- Prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims through improved intra and inter-agency working.
- Identify from both the circumstances of this case and the homicide review processes adopted in relation to it, whether there is learning which should inform policies and procedures in relation to homicide reviews nationally in future and make this available to the Home Office.

5 Review Time Period

5.1 It remains unclear when Mr Smith first met Mr Barnes but it was believed to have been in approximately **[redacted]**. However, so as to be able to understand the events which led to the death of Mr Smith, the DHR also wished to fully consider the events of their lives from a much earlier period. This would help to identify any potential early warning signs and or opportunities for early intervention, on behalf of professionals and agencies.

5.2 A decision was taken that **[redacted]** was a proportionate starting point, with agencies being asked to exercise their professional judgement and include any other information which pre-dated **[redacted],** up to the time of Mr Smith's reported death and Mr Barnes's arrest on **[redacted]**.

6 Individual Management Reviews (IMR's)

6.1 At the start of the DHR process the Panel agreed that an IMR should be conducted by agencies in accordance with the Home Office Guidance.[11] This determines that the aim of an IMR is to:

- 'Allow agencies to look openly and critically at individual and organisational practice and the context within which people were working together to see whether the homicide indicates that changes could and should be made.
- To identify how those changes will be brought about.
- To identify examples of good practice within agencies'.

6.2 In this specific DHR the following areas were addressed in the IMR's and examined by the DHR Panel:

- 'Mr Smith's contact with any specialist domestic abuse agencies or services[12]. The response of these services and to what extent was information shared in order to achieve a multi-agency safety plan.
- Mr Smith's contact with any targeted services[13]. The response of these services and to what extent was information shared in order to achieve a multi-agency safety plan.
- Mr Smith's contact with any universal services[14].The review will address whether there were any warning signs that agencies could have identified, the agencies risk assessment and process, the response of these services and to what extent was information shared in order to achieve a multi-agency safety plan.
- Mr Barnes's contact with Mental Health Services[15].The review will address whether there were any warning signs that agencies could have identified, the agencies risk assessment and process.
- Mr Smith and Mr Barnes's contact with Devon and Cornwall Police. The review will address whether there were any warning signs that agencies could have identified, the agencies risk assessment and process.
- Whether there were any barriers experienced by Mr Smith, or his family/friends/colleagues, in reporting any abuse in Cornwall or

[11] Page 18: Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Revised August 2013).

[12] Domestic Violence and Abuse Services in Cornwall.

[13] For more acute and complex cases following individual referral and specialist assessment.

[14] Also known as 'Primary Care'. These are services that anyone can access from healthcare professionals, who act as the first point of consultation for all patients in the healthcare system e.g. GP's, Dentists, Opticians etc. (Common chronic illnesses including depression).

[15] Also known as 'Secondary Care'. These are healthcare services provided by medical specialists and other health professionals who do not have first contact with patients e.g. Hospital care, Adult Mental Health Services (Community Mental Health Team, Mental Health Nurses, Psychologists, Psychiatrists etc.).

elsewhere, including whether he knew how to report domestic abuse should he have wanted to.
- Whether Mr Smith had experienced abuse in **[redacted]** in Cornwall or elsewhere and whether this experience impacted on his likelihood of seeking support in the months before he died.
- Whether there were opportunities for professionals to 'routinely enquire' as to any domestic abuse experienced by Mr Smith that were missed.
- Whether Mr Barnes had any previous history of abusive behaviour to an intimate partner and whether this was known to any agencies.
- Whether there were opportunities for agency intervention in relation to domestic abuse regarding Mr Smith or Mr Barnes that were missed'.

6.3 The Panel requested the following Organisations to carry out IMR's of their agencies involvement and produce reports. Organisations were encouraged to make recommendations within their IMR's and these were accepted and adopted by the agencies who commissioned the reports. They also helped form the basis for the DHR Panel Action Plan.

- Devon and Cornwall Police.
- Adult Mental Health Services (AMHS) Organisation.
- NHS England.
- Cornwall and Isles of Scilly Drug and Alcohol Action Team (DAAT).
- LGBT Organisation.
- Registered Social Landlord 1.
- Registered Social Landlord 2.

6.4 Requests were also made of the National Probation Service (South West & Central); Domestic Violence and Abuse Services in Cornwall; Cornwall Council Education, Health & Social Care and Healthy Gay Cornwall. None reported any contact with either Mr Smith or Mr Barnes, apart for minimal contact with Mr Smith for Social Care, which did not require an IMR to be completed

7 Involvement with Mr Smith's family and Mr Barnes

7.1 Home Office Guidance[16] states that the DHR Panel should carefully consider the potential benefits gained by including family, friends and colleagues from both the victim and perpetrator networks in the review process. This can help the DHR Panel to get a more complete view of the lives of the victim and perpetrator in order to see the homicide through the eyes of the victim and perpetrator and help them understand the decisions and choices the victim and perpetrator made.

7.2 The Independent Chair made early contact with the police SIO and Family Liaison Officer from Devon and Cornwall Police. Letters explaining the DHR

[16] Page 16: Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Revised August 2013).

process and offering the opportunity to contribute to the DHR and to receive its findings and recommendations were prepared. The letters also contained relevant leaflets that the Home Office has made available on its website and the draft terms of reference for the DHR, for their comment. Neither Mr Barnes nor his family, have so far responded to the letters which were sent to them. The police Family Liaison Officer spoke to Mr Smith's family and handed letters to Tony and Chloe. Whilst Chloe chose not to be involved in the DHR process, her brother Tony and their mother Joyce, agreed to a proposal from the Independent Chair to have an initial meeting. This was despite Tony believing they may not have anything to contribute to the DHR.

7.3 On **[redacted]**, Tony and Joyce met with the Independent Chair and Domestic Abuse and Sexual Violence Strategy Manager and the DHR process was explained to them. They were pleased with the outcome of the meeting; agreed to contribute further to the DHR and have continued to be engaged since. There has been a clear commitment by the Independent Chair and the Domestic Abuse and Sexual Violence Strategy Manager, to maintain contact with Mr Smith's family.

7.4 The draft terms of reference for the DHR were amended to take account of the following three specific areas Mr Smith's family requested further information on:

- 'Why did the Police not prosecute Mr Barnes the first time, even though [**redacted]?** Why did the police not take it further?
- Mr Barnes went into **[redacted],** how was he monitored by Mental Health/Social Services etc.? The Police told us he went to **[redacted].** Why was he **[redacted].** How you assess if someone is a risk back in the community? What community based support did he have?
- Did Mr Barnes's Doctor know his case history **[redacted]?** He was **[redacted].** Was he getting counselling? How was the Doctor monitoring Mr Barnes? Was Mr Barnes supervised at all? He was staying at Mr Smith's home on an informal basis but still allowed to keep his flat in …….'.

7.5 The Independent Chair met with Tony and Joyce to share the draft overview report and their comments are detailed at page 27, paragraph 10.39. The Independent Chair, together with the Domestic Abuse and Sexual Violence Strategy Manager, subsequently met with Tony to share the revised draft overview report and his comments are detailed at page 27, paragraph 10.40.

8 Equality and Diversity

8.1 All of the grounds for discrimination or nine protected characteristics[17], contained in the Equality Act 2010, were considered by both the IMR authors and the DHR Panel. This was a homicide involving a victim and perpetrator

[17] Age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, sex, sexual orientation, religion or belief and race.

who were experiencing complex issues, including **[redacted]**. The DHR Panel, together with the independent LGBT domestic violence and abuse expert, comprised of professionals who were able to provide expert knowledge and advice of the key issues.

9 Summary of Background

9.1 This section has been brought together from the Agencies IMR's to give an overview summary. In a chronological order, it provides background information for the time periods concerning the following:

Mr Smith's life up until meeting Mr Barnes

9.2 Mr Smith was **[redacted]** years of age at the time of his death. He had been living in Cornwall for a number of years, having married Joyce in **[redacted]**; separated in **[redacted]** and divorced in **[redacted]**. They remained friends, with Mr Smith referring to Joyce as 'the light of his life'. In addition to Tony and Chloe, he had **[redacted]**. Whilst Mr Smith led an independent life, he was regarded as a sociable person, who was very close to his family. **[Redacted]**.

9.3 From the late **[redacted]** Mr Smith had a history of **[redacted]** dependency. He received help and support over many years from his General Practitioner (GP) Practice and the Adult Mental Health Services (AMHS) Organisation, who worked to meet his health needs.

9.4 From **[redacted]**, right up to the time of Mr Smith's death in **[redacted]**, his GP and the AMHS Organisation records detail **[redacted]** consultations for his **[redacted]**. This included offers of **[redacted]**; referrals to **[redacted]** and specialist placements at **[redacted]**.

9.5 Mr Smith made determined efforts to complete **[redacted]** courses with varying levels of success. He would seek help from his GP Practice and his medical condition would be reviewed, including an assessment by the AMHS Organisation. He would then be offered rehabilitation courses and counselling. When Mr Smith was not dependent **[redacted]** his health improved, but during periods when he was **[redacted]** dependent, this impacted on his overall health and at times made him [**redacted]**. Throughout this whole period he was consistently supported and encouraged by his GP Practice and received regular assessments from the AMHS Organisation.

9.6 Following his earlier divorce and having been assessed for 'general needs accommodation', Mr Smith lived in a one bedroomed, first floor flat[18], from **[redacted]** up until his death. **[Redacted]**. It is believed that Mr Smith first met Mr Barnes in **[redacted]** and then Mr Barnes became a paying lodger in Mr Smith's home in **[redacted]**. He had given Mr Smith's address as his temporary address from **[redacted]**.

[18]Registered Social Landlord 1: Independent, not for profit Housing Association and member of the Registered Social Landlord (RSL) Group in Cornwall. (Housing Associations provide low cost social housing for people with housing need).

9.7 In August **[redacted]** Mr Smith met with a Community Advocate from the LGBT Organisation[19]. He said he **[redacted]**.

Mr Barnes's life up until meeting Mr Kay

9.8 Mr Barnes was **[redacted]** years of age at the time of Mr Smith's death. He had lived with his father and mother Mr and Mrs B. Barnes, until their deaths in **[redacted]** respectively. He was also the full time carer for his Uncle Mr Newton, until Mr Newton required residential care in **[redacted]**. The family had lived in the same home[20] in Cornwall since **[redacted]**. His Aunt Mrs East lived **[redacted]** and was supportive to him. He described himself as **[redacted]**.

9.9 Mr Barnes had his first contact with the secondary care AMHS Organisation in **[redacted]**. He felt **[redacted]**. There was then nearly a ten year gap, with no information available from his GP Practice, or the AMHS Organisations records. In January and February **[redacted]** Mr Barnes saw his GP four times after **[redacted]** and then between February **[redacted]** and February **[redacted]**, there were eight reported incidents of Mr Barnes **[redacted]**. This resulted in him being admitted as an in-patient at **[redacted]** and then his voluntary[21] admission to an AMHS Organisation Hospital **[redacted]**, for further assessment and treatment. These were for varying periods of time, with extended periods of home leave.

9.10 He was managed under the Care Programme Approach (CPA) .The CPA had been introduced in **[redacted]** to provide a framework for working with people with complex mental health needs and who required specialist Mental Health Services e.g. Community Mental Health Team (CMHT)[22]. The CPA enabled care to be delivered to meet identified health and social care needs. A care plan is coordinated by one person, but provided by others. The Care Coordinator is responsible for ensuring the care provided, with regular reviews of the care plan, as the need arises, to meet individual needs and as a minimum, at six monthly intervals.

9.11 In April **[redacted]** Mr Barnes disclosed being aggressive at times and kicking his **[redacted]** car. A note in his GP records said he accepted he may be **[redacted]**. In May **[redacted]** he was diagnosed with **[redacted]**. There was reference on a housing referral form to Mr Barnes having: 'unresolved anger

[19] An Organisation which supports Lesbian, Gay, Bisexual and Trans People and Communities in **[redacted]**.

[20] Registered Social Landlord 2: Not for profit charitable registered provider of social and affordable housing. (Also a member of the RSL Group in Cornwall).

[21] If someone agrees to be admitted to a psychiatric ward or unit, they are called a voluntary or an 'informal' patient. Where someone is admitted to hospital under Part 111 of the Mental Health Act 1983, they are called a 'formal' patient. The term 'sectioned' is also used to describe a compulsory admission to hospital.

[22] Community based assessment and treatment service for people suffering from mental health problems who are over the age of 18.The team include Mental Health Nurses, Psychologists and Psychiatrists.

leading to violence to property and people', 'assaults on property due to frustration' and 'assaults on Uncle (Mr Newton), which Mr Barnes denies'.

Mr Barnes's [redacted] with Mr Kay

9.12 Between February and June **[redacted]** Mr Barnes was voluntarily admitted to an AMHS Organisation Hospital. On discharge home his care was managed under the CPA. He was discharged from social care caseload as it was reported he would not engage and his needs would be best met by the CMHT. This decision was challenged by a Consultant Psychiatrist who believed social care was necessary. Throughout the remainder of **[redacted]** Mr Barnes was regarded as stable and doing well, with support and regular review by his GP and the Community Psychiatric Nurse[23].

9.13 It is believed it was during this time, or in **[redacted]** Mr Barnes first met Mr Kay. He said they **[redacted]**, but Mr Kay denied this. In November **[redacted]** Mr Barnes said whilst he had **[redacted]** at times, he did not want his **[redacted]** with Mr Kay to end. In February **[redacted]** Mr Barnes told his GP he felt **[redacted]** and at a CPA review in November **[redacted]** told his CPN he **[redacted]**. In June **[redacted]** Mr Barnes told his CPN that his Aunt Mrs East had accused him of 'pushing her' which Mr Barnes denied when questioned further by the CPN.

9.14 From July **[redacted]** through to January **[redacted]**, there were several periods of time when Mr Barnes was either **[redacted]** with Mr Kay, or Mr Kay had left and moved away. The effect on Mr Barnes's mood was documented in his medical notes. **[Redacted]**.

9.15 On **[redacted]** Mr Barnes was admitted to **[redacted]** following **[redacted]**. Mr Barnes had argued with Mr Kay and when seen by his CPN, Mr Barnes said he had 'hit' Mr Kay during the argument, but still **[redacted]**, despite always leaving Mr Barnes. The CPN noted that Mr Barnes was 'remorseful, more rational and a lot calmer, although that could all change when he next has contact with Mr Kay'. On **[redacted]** the CPN recorded that Mr Barnes *'*spoke of (laughingly) about how he had purchased gaffer tape and had planned to tape Mr Kay up and keep him there with him*'*. When the CPN asked him about this comment Mr Barnes 'laughed, stating he knew it was a ridiculous idea and clearly stated he would not really do such a thing'.

9.16 At about 4.30pm on **[redacted]**, Mr Kay, who was **[redacted]** years of age by now, had planned to leave Mr Barnes's home to visit **[redacted]**. Mr Barnes did not want him to leave and without warning, hit him **[redacted]**. Mr Barnes then picked up a large carving knife and forcibly restrained him against his will **[redacted]**. He initially **[redacted]** and then held him overnight, with the threat of **[redacted]**. At about 7.45am the next morning, Mr Kay escaped after Mr Barnes **[redacted]**, just prior to contacting the CMHT. A CPN and Paramedics

[23] Registered nurse with specialist training in mental health, providing counselling, offering support to those with long term mental health conditions and administering of medication.

went to Mr Barnes's home and Mr Barnes was firstly taken to **[redacted]** and then on **[redacted]**, he accepted voluntary admission to an AMHS Organisation Hospital. Due to his **[redacted]** and hospital admission, the police were unable to arrest or interview Mr Barnes regarding the false imprisonment of Mr Kay, at that time.

Mr Barnes's life after the false imprisonment of Mr Kay, up until meeting Mr Smith

9.17 A decision was taken that Mr Barnes would remain at the AMHS Organisation Hospital to provide support to him, but not as part of a further mental health assessment. On **[redacted]**, Mr Barnes was arrested and interviewed regarding the false imprisonment of Mr Kay. The following day he was discharged from the AMHS Organisation Hospital. His care was delivered under the CPA framework, with a care plan coordinated by his CPN. Later that month Mr Barnes reported to his CPN that he was being 'taunted' by **[redacted]** and was 'ventilating' **[redacted]** about Mr Kay.

9.18 On **[redacted]** Mr Barnes was assessed by a Consultant Psychiatrist. The police had requested a psychiatric report be prepared, which would assist in the decision making process for Mr Barnes, in relation to the false imprisonment of Mr Kay. The Consultant Psychiatrist said 'I do not think Mr Barnes is a danger to the public at large at all' and that the 'enormity of court proceedings are likely to result in Mr Barnes **[redacted]**. Following receipt of the psychiatric report and file of police evidence, a decision was taken by Devon and Cornwall Police, that Mr Barnes would be cautioned by the police for the offence of false imprisonment. He accepted his caution on **[redacted]**.

9.19 As of **[redacted]** Mr Barnes continued to be seen by his GP, Psychologist, CPN and Health Care Assistant. His mental health notes showed **[redacted]** was planned. He felt **[redacted]** would 'insult him if he goes out' and **[redacted]** continued to worry him. He was talking frequently of Mr Kay and appeared **[redacted]**. His **[redacted]** and a Counsellor in Psychology **[redacted]** that Mr Barnes was **[redacted]**. In June **[redacted]** Mr Barnes was given the offer to exchange to a smaller bungalow. He declined this and on **[redacted]** took over the legal tenancy of the property which his parents Mr and Mrs B. Barnes had previously been the legal tenants of, since **[redacted]**. An entry in the GP records of **[redacted]** recorded that Mr Barnes was stable; with no signs of anxiety and so following this review, no further appointments were made.

9.20 In November **[redacted]** Mrs East contacted Mr Barnes's CPN to express concern he had been victimised on Halloween night by people throwing eggs at his home and shouting abuse at him. Mr Barnes told his CPN it 'would not have helped if he had gone outside waving a carving knife'. In July **[redacted]** Mr Barnes alleged an unknown person had deliberately driven a car at him, only diverting at the last minute. In August **[redacted]** Mr Barnes was assessed and appeared to be 'coping' with the transition away from the AMHS Organisation. He was regarded as 'low' for risk of relapse of neglect, suicide and harm to others.

9.21 In January **[redacted]** Mr Barnes stopped seeing his Counsellor in Psychology **[redacted]** as he felt 'their work has finished'. His GP was advised by the Counsellor who said 'he has **[redacted]** in the past and I would be pleased to see him at any time if you think it appropriate'. On **[redacted]**, having maintained 'good progress,' Mr Barnes was formally discharged from the secondary care AMHS Organisation by his CPN, who advised the GP to 'refer back if you have any concerns'. By May **[redacted]** Mr Barnes was referred by his GP for counselling, due to being **[redacted]**. This was followed up at the end of July **[redacted]**, with a further GP referral to the AMHS Organisation, for an expert review on the management of Mr Barnes's condition and medication.

9.22 On **[redacted]** Mr Barnes was given 'words of advice' by the police after a report of two men **[redacted]** in a public toilet. (He was later to be given further police 'words of advice' having been found **[redacted]** in public toilets with other men in **[redacted]**). On the last occasion Mr Barnes said he had travelled to another town as a result of threats of violence towards him in his home town.

9.23 On **[redacted]** Mr Barnes saw his CPN who reported Mr Barnes appeared 'better than he had ever seen him before' and on **[redacted]** Mr Barnes was seen by a Consultant Psychiatrist. He was assessed as **[redacted]** and was discharged from the secondary care AMHS Organisation. In October **[redacted]** Mr Barnes was referred by his GP for counselling and assessment by the secondary care AMHS Organisation, following concerns he **[redacted]**. He was not accepted for secondary care by the AMHS Organisation and was advised to see the Practice Counsellor and attend **[redacted[24]]**. Between January and May **[redacted]** Mr Barnes attended two counselling sessions before cancelling further appointments.

9.24 There was then no further contact with the secondary care AMHS Organisation for the next four years. On **[redacted]** Mr Barnes visited his GP and requested further involvement with the secondary care AMHS Organisation. On **[redacted]** Mr Barnes's case was discussed and screened out as he did not meet the criteria for assessment. In November **[redacted]** Mr Barnes's GP wrote to **[redacted[25]],** to request counselling for Mr Barnes as he was **[redacted]**. It is not clear if he received any counselling. Mr Barnes's only other contact with the secondary care AMHS Organisation was on **[redacted]**, shortly after his arrest and detention on suspicion of the murder of Mr Smith. This was for a mental health assessment where no mental health disorder was detected.

[24] AMHS Organisation resource service in **[redacted]**, which worked with service users aged 18 to 65 years, who were recovering from mental health illness. Helps service users to lead independent lives.

[25] Independent agency delivering private and NHS counselling services, helping service users 16+ recover from common mental health problems e.g. depression.

Mr Smith's [redacted] with Mr Barnes

9.25 It is unclear exactly when Mr Smith met Mr Barnes, or how often Mr Barnes stayed at Mr Smith's home. An entry in Mr Barnes's GP records showed he gave Mr Smith's address as his temporary address from **[redacted]**. It is believed he became a lodger at Mr Smith's invitation from **[redacted]**, with Mr Barnes paying Mr Smith £50 per week. Mr Barnes said he and Mr Smith were **[redacted]**. He described himself as **[redacted]**. In respect of Mr Smith it is believed he told his neighbours that Mr Barnes was his cousin.

9.26 In October **[redacted]** Mrs East confirmed to Registered Social Landlord 2 that Mr Barnes was still living in his own home after it was thought the property might have been 'abandoned'. She explained Mr Barnes suffered from **[redacted]** and avoided contact with people. On **[redacted]**, an anonymous telephone caller alleged a disturbance at Mr Smith's home. When the police attended, the flat was in darkness and there was no sign of any disturbance.

9.27 Throughout February to May **[redacted]** Mr Smith's GP recorded he had gone from being in a positive mood and ready for further hospital based **[redacted]**, to being **[redacted]** but **[redacted]**. Tony recalled how in February **[redacted]** his Father had **[redacted]**; was a completely different person and wanted to 'get rid of Mr Barnes, to kick him out'. Whilst Mr Barnes was away from Mr Smith's home during the month of April **[redacted]**, Mr Smith relapsed. Tony said he told his Father 'to go and apologise and get him (Mr Barnes) back', as it was clear to his family that he (Mr Smith) was not coping well on his own.

9.28 Mr Smith's family knew little about Mr Barnes, but believed him to be going through a divorce and someone who would regularly stay at Mr Smith's home. They said he appeared to 'moderate' Mr Smith's **[redacted]** and generally 'kept his home in order'. They had no concerns whatsoever about Mr Barnes and said 'it relieved their minds that someone was living there with Mr Smith' and that Mr Barnes had been 'nothing but a positive influence' on Mr Smith. On **[redacted]** at a tenancy visit, Mr Smith indicated he was living alone at the property. On **[redacted]** the police spoke to Mr Smith and his daughter Chloe in relation to a **[redacted]** dispute.

9.29 Between **[redacted]** and the date his death was reported, Mr Smith did not attend three planned GP medication review appointments. He had asked to commence **[redacted]** and had been due to start this on **[redacted]**.On that date it is believed Mr Smith had an argument with Mr Barnes because he would not help him with his **[redacted]** programme. Chloe saw her Father at his home and was told that he had 'kicked out' Mr Barnes following this dispute. By **[redacted]** Mr Barnes had returned at Mr Smith's request and the two of them were seen by Tony on **[redacted]** when he visited. On **[redacted]** two **[redacted]** carried out work at Mr Smith's home and by description both Mr Smith and Mr Barnes were present. On this same date it appears Mr Smith was involved in a verbal disagreement with **[redacted]**.

9.30 There is unconfirmed information that on **[redacted]** Mr Smith asked Mr Barnes to accompany him to a GP appointment in relation to his proposed **[redacted]** programme. After initially agreeing to support and accompany Mr Smith to the GP surgery it appears Mr Barnes felt unable to, which caused a disagreement between them, resulting in Mr Barnes being asked to leave. Subsequent to this Mr Smith contacted Mr Barnes and he returned to Mr Smith's home[26].

9.31 On **[redacted]** Chloe helped her Father to complete some financial papers. When she arrived to see him she was 'surprised' to see Mr Barnes back in her Father's home. Mr Smith had regularly complained to Chloe about Mr Barnes being in the flat together and sometimes wanting his own space and so as a result Mr Barnes would occasionally return to his own home. Chloe said that her Father told her 'ten to fifteen times' that he was going to ask Mr Barnes to leave for good.

9.32 On **[redacted]**, the day of Mr Barnes's birthday, a **[redacted]** visited Mr Smith at his home for a meal. Mr Barnes was also present. The **[redacted]** recalled that at some stage in late May **[redacted]**, there had been an argument between Mr Smith and Mr Barnes, resulting in Mr Barnes being asked to leave. Mr Smith later told the **[redacted]** that they had 'patched up' their differences and Mr Barnes had returned. Mr Smith cooked a meal for the three of them and the **[redacted]** then left at 7.30pm.

9.33 After **[redacted]** there were no other reported contacts, with either Mr Smith or Mr Barnes, until **[redacted]**, when Tony went to deliver a **[redacted]** to Mr Smith. He was unable to get a response at his home so left. Later that day he returned as he was concerned for the welfare of his Father. Together with a friend they were able to gain access to Mr Smith's home and found the body of Mr Smith **[redacted]**.

9.34 The Police were called at 7.40pm and saw Mr Smith's body on the bed **[redacted]**. A paramedic recognised life extinct **[redacted]**. A later post mortem was unable to provide a definitive cause of death, **[redacted]**.

9.35 A major police investigation commenced, with a priority to locate Mr Barnes. It appeared he left Mr Smith's home sometime after 12.15pm, on **[redacted]**. He was then eventually arrested at 9.30pm, on **[redacted]**, having spent **[redacted]** days travelling around the country using Mr Smith's identity and credit card. Prior to police interviews on **[redacted]**, Mr Barnes was subject to a mental health assessment. He was deemed mentally fit for interview and detention, with no mental health disorder detected. During this assessment Mr Barnes admitted killing Mr Smith and drew comparison with his previous offence of **[redacted]** when he said 'I did what I did but this time he died'. He

[26] This information is contained in the Devon and Cornwall Police IMR, but may in fact be referring to the 25 May 2012 disagreement. There is nothing in Mr Smith's GP notes to suggest he was due to see his GP on 1 June 2012.

told the assessing Doctor's that he had recently thought about 'hitting people and **[redacted]** people'.

9.36 Mr Barnes said living in his own home was 'very uncomfortable' and **[redacted]**. He said he found it very difficult to **[redacted]**, despite support from the Mental Health Team. He said he had been threatened **[redacted]** and ended up living in one room, with the curtains drawn, **[redacted]** himself away.

9.37 Mr Barnes stated he had met Mr Smith **[redacted]** years previously' on a bus. He said initially he would visit Mr Smith for the day, then for two days and later for a week at a time. He said he moved in just before Christmas **[redacted]** as a paying lodger. At the end of **[redacted]** Mr Barnes said he was due to help Mr Smith with his **[redacted]**, but it would mean having to go to the GP surgery with him on a daily basis. He was reportedly unhappy with his **[redacted]**, which he said resulted in him suffering from **[redacted]**. He said they argued and he left, but was called by Mr Smith on **[redacted]** and asked to come back which he did. He said that Mr Smith was **[redacted]** and was argumentative that week. He stated Mr Smith would ask him to leave and then apologise the next day.

9.38 Mr Barnes said on the morning of **[redacted]**, Mr Smith asked him to go out and get some sherry. Mr Barnes said his fear of going out was great and 'for some reason I lost control'. He said he **[redacted]** from the kitchen, followed Mr Smith into the **[redacted]** where he then **[redacted]** He said he did not want Mr Smith **[redacted]** so then decided to **[redacted]**. He said that Mr Smith had **[redacted]**, but he continued **[redacted]**.

9.39 Mr Barnes said they only ever had verbal arguments which were due to Mr Smith's **[redacted]** dependency. He said he had **[redacted]** He felt that should he **[redacted]**, then Mr Smith might ask him to leave his home, although he had never actually said this to him. **[Redacted]**.

9.40 On **[redacted]** Mr Barnes was charged with Mr Smith's murder and on **[redacted]**, he pleaded guilty to murder. He received a life sentence with a minimum tariff of 15 years. The Trial Judge said:

> 'You have a past. In **[redacted]** you were involved in a very serious incident, as I see it, of false imprisonment when you detained the victim on that occasion against his will and acted out a fantasy that you had of applying restraints to him and he was detained for some hours. The matter was eventually resolved by you being cautioned. You had been admitted in the aftermath of the incident to a local psychiatric hospital, having taken an overdose. I have seen and read an extract from a report that was prepared at that time. Following your release from that hospital, it appears as if you have either not required or you have avoided any psychiatric assessment or treatment. It is highly questionable whether it was in the public interest that the matter should have been resolved as it was at that time. And there is no doubt that

> the killing of Mr Smith evidenced once again that same fantasy when his body was found…It was a wicked act and Mr Smith, a much loved and missed man met his death in quite appalling circumstances… You had clearly been harbouring thoughts of killing Mr Smith for some days and killing him in exactly the way that you did. This was in no sense a domestic incident and could not properly be characterised as such[27]. It was not an act of killing but[28] was in any sense spontaneous. It had been in your mind… The starting point for the assessment of the minimum term is 15 years. That is to some extent aggravated by the fact that this was a premeditated killing.'

9.41 On **[redacted]**, a Coroner's Inquest was held into Mr Smith's death. Her Majesty's Coroner for Cornwall recorded the verdict and sentence of the Crown Court that Mr Smith had been unlawfully killed. She stated any lessons learned should be identified by the DHR process.

10 Conclusions

10.1 A natural question to ask is if Mr Barnes had been dealt with differently in relation to the false imprisonment crime of **[redacted]**, might there have been a different outcome in relation to Mr Smith? It cannot be said with certainty that an intervention at that stage could have led to a different outcome.

10.2 There had been a period of over a decade **[redacted]** between the false imprisonment crime and the death of Mr Smith. At the time of Mr Smith's death it is probable the two men had known each other for over **[redacted]** years; with no information known in any organisation, to indicate Mr Smith was the victim of domestic violence or abuse, or at risk from Mr Barnes. The only known agency that was involved with Mr Smith and Mr Barnes to any extent, at that time, were the two GP Practices. The family of Mr Smith had no concerns over Mr Barnes; regarded him as a positive influence on Mr Smith and could not see how Mr Smith's death could have been prevented. They added that even if Mr Smith had known of Mr Barnes's past history, they believe it would have made no difference to him allowing Mr Barnes to stay in his home.

10.3 Clearly, responsibility for Mr Smith's death rests with Mr Barnes. The DHR Panel concluded there was no immediate or obvious point, at which action could have been taken, by an individual or single agency, to prevent what happened to Mr Smith. The DHR Panel has also concluded, from the accumulated evidence, it is very unlikely Mr Smith's death, in **[redacted]**, could have been predicted, or was preventable.

[27] This comment was raised by the Home Office DHR Quality Assurance Panel and it is the view of the DHR Panel that this was a domestic incident. (Recommendation at page 30, paragraph 11.24).

[28] The Court transcript says the word 'but', however it may be possible that the Judge said either 'that' or 'which'.

10.4 When reviewing the time period leading up to **[redacted]** and beyond, it is important to be proportionate and balanced, when considering what were the expectations of the various agencies and their staff, at that particular time of their involvement. The working practices, policies, procedures and knowledge of all the agencies and their staff in the year **[redacted]** as an example, will have been different to what they are now. Today, services are more robust and cover a much wider knowledge, understanding, approach and response to domestic violence and abuse; LGBT specialism; adult safeguarding; multi-agency networks, including direct links to specialist domestic violence and abuse services, etc. There would for example, be a more accurate assessment of levels of risk and dangerousness. This is due to the fact that all agencies now have much more robust practices and these issues are embedded into their everyday working practices, policies and procedures.

10.5 DHR's are not about apportioning blame: they provide a very important opportunity to learn lessons and improve services. This DHR has brought into focus, the need to ensure agencies: receive, or have received appropriate training; adhere to the NICE Guidelines[29] and use the IRIS approach. A number of recommendations have been made; agreed at a senior level and an Action Plan produced. It is now important to ensure the plan is implemented and delivered by Safer Cornwall Partnership (SCP), within agreed timescales. The recommendations are based on the learning and conclusions reached in this Overview Report. They include, but are not limited to those made in the agencies IMR's and are focussed; specific and capable of being implemented.

10.6 Devon and Cornwall Police should not have made the decision to caution Mr Barnes for false imprisonment in **[redacted]**, without firstly referring the evidential file to the CPS for advice. It was recognised policy and procedure at that time and remains so now. It is unknown what the CPS may have advised, but it is the view of the DHR Panel is that this was a very serious incident, including false imprisonment and domestic violence and abuse and Mr Barnes should have been prosecuted through the criminal justice system. The police should have assessed the incident appropriately, given the police guidance available at the time. Today, the false imprisonment and domestic violence and abuse crimes; conviction and potential prison sentence for violent crimes, would have led to a MARAC Panel and Mr Barnes potentially being made subject of a Level 2/3 MAPPA, with a medium to high level of risk. This may have afforded appropriate levels of safeguarding management for his onward return back into the community.

10.7 It is important for Devon and Cornwall Police to carry out an audit to establish if prosecution advice files, containing allegations of indictable only offences are being referred to the CPS for charging advice.

[29] (NICE) Guidelines [PH50]; Domestic violence and abuse; multi-agency working, 2014.

10.8 Mr Smith was **[redacted]** years of age at the time of his death. It was unknown to what extent, that he had been the victim of domestic violence and abuse from Mr Barnes or anyone else. If he had been then he did not appear to disclose this to anyone. Devon and Cornwall Police had no evidence of any reported domestic violence, or abuse, between Mr Smith and Mr Barnes. The only information they had was the anonymous telephone call, reporting a 'disturbance' at Mr Smith's home on **[redacted]**. Even then, when the police attended, they found no evidence to confirm the anonymous report. It was only when the police investigation began into Mr Smith's death that one **[redacted]** reported Mr Smith and Mr Barnes had a disagreement at the end of May **[redacted]** and **[redacted]** of Mr Smith, said **[redacted]** Mr Barnes throwing a saucepan at Mr Smith's arm, on one unknown occasion.

10.9 This DHR has highlighted the need to raise awareness regarding LGBT and older male victims of domestic violence and abuse. LGBT domestic violence and abuse are under reported. The Crime Survey, England and Wales, suggests that 17% of all victims are male, although that covers mainly heterosexual men. A more coordinated gender specific approach is needed to encourage LGBT victims and in particular older male victims, to report domestic violence and abuse and access services. The findings of the LGBT Organisations **[redacted]** survey may also provide an opportunity to identify any relevant themes.

10.10 The introduction of Devon and Cornwall Police's Sexual Offences and Domestic Abuse Investigation Teams (SODAIT) and their action plan arising from recommendations made following the Her Majesty's Inspector of Constabulary's inspection of 2014, into 'Devon and Cornwall Police's approach to tackling Domestic Abuse', provide opportunities to improve services. This includes reviewing training plans so members of the SODAIT and Call Handlers, Call Takers and Control Room Staff, can receive LGBT and older male victims of domestic abuse awareness training. This training could also form part of the domestic abuse training given to new recruits. The DHR Panel welcomes the HMIC report of December 2015, which acknowledges the progress Devon and Cornwall Police has made with their action plan, since 2014. However, the HMIC report of 2015 highlights the need to ensure investigations into serious crimes are of the required standard, with proper supervision and the SODAIT has sufficient staff, with the appropriate professional skills and experience, to investigate cases.

10.11 It is important to scope local specialist LGBT services, to offer the Safer Cornwall Partnership (SCP) two day Association of Chief Police Officers (ACPO) Domestic Abuse, Stalking and Harassment and Honour based Violence (DASH) Awareness/ Risk Assessment and 'Routine Enquiry into Domestic Violence and Abuse' training. This training will help staff identify, risk assess and refer where appropriate, high risk cases of domestic abuse and allow early intervention. The two day SCP training should also have reference to domestic abuse within the LGBT community, including older people. The DHR Panel also believes it is important to identify LGBT groups who are willing to provide LGBT awareness training to non LGBT specialist

agencies. The LGBT expert has emphasised the point that any training delivered as a result of this DHR must involve specialist LGBT domestic violence and abuse agencies/trainers such as Broken Rainbow, the Diversity Trust and Respect.

10.12 The SCP will also need to review how additional update awareness training information, can be delivered to those agencies (and the police), who have already undertaken the two day training and to incorporate it into the current training programme from an agreed point. As part of this review, the SCP should also include how any potential LGBT awareness training can be delivered by LGBT services to non LGBT specialist agencies. The training should include understanding of the nature and dynamics of domestic violence and abuse as a pattern of coercive controlling behaviour and have reference to the NICE Guidelines and recommendations [PH50]: (Domestic Violence and abuse: multi-agency working, 2014)[30].

10.13 There has been detailed consideration throughout this DHR process as to whether or not Mr Smith and Mr Barnes were 'vulnerable' adults, with reference to the 'No Secret's' definition and had mental capacity with reference to the Mental Capacity Act 2005. The DHR Panel concluded that whilst both men had well documented complex needs, neither reached the threshold. Both could have met the disability definition in the Equality Act 2010, but being disabled and in Mr Smith's case an older person, does not necessarily make you vulnerable. Both Mr Smith and Mr Barnes had capacity, were able to make decisions, protect themselves and able to access services.

10.14 The Government Response in July 2012, to the Law Commission Report 326 on Adult Social Care May 2011, made the following observations:

- …'the person is the best judge of their own wellbeing, except in cases where they lack capacity to make the relevant decision.
- …follow the individual's views, wishes and feelings wherever practical and appropriate.
- …ensure that decisions are based upon the individual circumstances of the person and not merely on the person's age or appearance, or a condition or aspect of their behaviour, which might lead others to make unjustified assumptions'.

10.15 Whilst Mr Smith was involved with the secondary care AMHS Organisation between **[redacted]** and **[redacted]**, today, his mental health needs would be met in primary care, rather than the secondary care provided by the AMHS Organisation. He would not meet the threshold for the secondary care AMHS Organisation. At that time he was not assessed as high risk for the AMHS Organisation Supervision Risk Register; not subject to the Care Programme Approach (CPA), or a Community Care Assessment (CCA). With his **[redacted]** documented **[redacted]** dependency and periods of **[redacted]**, his needs were best met by the AMHS Organisation, rather than through Adult

[30] (NICE) Guidelines [PH50]; Domestic violence and abuse; multi-agency working, 2014.

Social Care. That was accepted practice then and is so now. He led an independent life; was offered appropriate treatment and interventions and his risks were identified and effectively managed.

10.16 Whilst Mr Barnes was involved with the secondary care AMHS Organisation between **[redacted]** and **[redacted]**, it is most likely that today his mental health needs would be met in primary care, as he would not meet the threshold for the secondary care AMHS Organisation. This view is supported by the assessment carried out following his arrest on **[redacted]**, when no mental health disorder was detected. The level of care provided was good practice at the time and would be considered good practice now.

10.17 The disclosures made by Mr Barnes of **[redacted]**, of him 'hitting' Mr Kay and on **[redacted]**, when he said he had purchased tape regarding tying Mr Kay up, were not taken further, other than asking questions and documenting the details. (As were the allegations of potential assaults by Mr Barnes upon his Uncle, Mr Newton and Aunt, Mrs East).The importance of Mr Barnes's behaviour and comments can now be seen in the light of the subsequent false imprisonment of Mr Kay. This was a significant crime committed by Mr Barnes and the outcome could have been even more serious, as evidenced by what Mr Barnes went on to commit against Mr Smith in **[redacted]**.He was not seen as a perpetrator of violent offences and the professional focus was of his risk to himself from **[redacted]**.

10.18 The AMHS Organisation psychiatric report on Mr Barnes, dated **[redacted]**, offset his risk. The result was that normal processes, from either becoming 'High Risk' under the AMHS Organisation Supervision Risk Register, or being placed into the criminal justice system, did not happen. The effect of this was that despite effective use of the CPA, Mr Barnes was not afforded a level of monitoring and assessment he may have received under the criminal justice system e.g. monitoring by the Probation Service. Whilst it is likely that the outcome may not have been any different, in **[redacted]**, Mr Barnes should have received a face to face assessment, to determine whether he should be referred to the secondary care AMHS Organisation, or not. Getting a more up to date assessment of his mental state and potential risk would have been good practice.

10.19 The timely sharing of the AMHS Organisation risk information must be made available through the **[redacted]** There is a need for the AMHS Organisation to resolve how potentially important information held in **[redacted]** for service users, who are not on **[redacted]**, will be made easily available to the AMHS Organisation clinical staff, who may become involved with service users, who are re-referred to the AMHS Organisation, such as Mr Barnes was. It is acknowledged this is important, so that all known information about risk is readily available.

10.20 This DHR Panel welcomes the fact that the AMHS Organisation continues to prioritise and target **[redacted]** staff to complete safeguarding, domestic violence and risk training; including ensuring that between 2014 and 2016, all

staff attend the SCP two day ACPO DASH awareness/ risk assessment training, followed by structured roll out of priority training for Routine Enquiry into Domestic Violence and Abuse in appropriate Mental Health Services. Making this training mandatory for all staff evidences the importance placed upon it by the AMHS Organisation.

10.21 The care and support provided by both NHS England GP Practices for Mr Smith and Mr Barnes and in particular the two main GP's, was evident, with a consistent approach between the primary care GP Practices and the secondary care AMHS Organisation, as and when required.

10.22 The DHR Panel has considered the question as to whether either GP Practice could have shown any more professional curiosity, or done any more. Although patients may not display obvious signs of symptoms of abuse, the volume of visits to healthcare environments, with a range of issues, over a period of time, may be a cry for help, where patients are not able to make informed decisions about their welfare. It is they who require ultimate support and guidance and intervention and are unlikely to seek it of their own volition.

10.23 However, unless patients lack competence, the acceptance of care and support rests with individuals. Adults are in charge of their decisions that affect their lives, even though those decisions might not be thought by others to be in their best interests. The DHR Panel concluded that both Mr Smith and Mr Barnes: had mental capacity; could make decisions; were able to protect themselves and access services.

10.24 Given the existence of various known risk factors e.g. **[redacted]** health etc., the DHR Panel considered whether there may possibly have been any opportunities for the GP Practices to be more proactive in enquiring about any potential domestic violence and abuse. It appears that Mr Smith was someone who kept his private life to himself. Was it likely that he would have disclosed anything, for example, **[redacted]**, or had been subject to domestic violence or abuse? The DHR Panel believes it is important for all GP surgeries in Cornwall to receive the IRIS training and use its approach, if they have not already done so. This will ensure that they are equipped to carry out domestic violence and abuse enquiry with female and possibly male patients. This DHR Panel welcomes the NHS England review of individual and joint training needs and has sought the support of the Medical Director regarding a potential review of the curriculum for GP's, specifically in relation to domestic violence and abuse and the Mental Capacity Act 2005.

10.25 With their strategic overview SCP need to ensure agencies incorporate the NICE guidelines and recommendations[31], as they specifically relate to training; multi-agency working and 'routine enquiry'. It is also important for SCP to ensure there are multi-agency networks, which include direct links

[31] (NICE) Guidelines [PH50]; Domestic violence and abuse; multi-agency working, 2014.

between the health services and specialist domestic violence and abuse services, providing support to victims and perpetrators. The LGBT expert said that distinguishing between domestic violence and abuse victims and perpetrators is complex and should be carried out by specialist domestic violence and abuse experts, rather than clinicians.

10.26 This DHR has highlighted the need for the development of multi-agency guidance for GP's, on working with frequent service users who present with the 'Toxic Trio' e.g. consideration of a multi-agency forum for them to discuss such complex cases with multi-agency partners. At the present time there is no mechanism in place, unlike there is with high risk domestic violence and abuse cases, through the MARAC process. The development of multi-agency guidance would also ensure a more consistent approach to regular risk assessments, which can be shared with other agencies; improve multi-agency pathways of care and potentially reduce delays in referrals between agencies for patient's treatment. The DHR Panel also believes that the 'Toxic Trio', with its potential impact on the 'Living Well' programme in Cornwall, should be part of the joint strategic needs assessment and a priority for the Cornwall Health and Wellbeing Board. The DHR Panel welcomes the supportive comments of the Chair of the Health and Wellbeing Board in this respect.

10.27 The IMR process has drawn agencies to examine adult safeguarding and child protection policies, relating to domestic violence and abuse. This DHR Panel considers the SCP should support the Local Safeguarding Children's and Adults Board's, in consideration of a wider review of the South West Child Protection Procedures, in relation to domestic violence and abuse and also a review of the Cornwall and Isles of Scilly Safeguarding Adult Policy.

10.28 Additionally, the DHR Panel believes it is important that a multi-agency practitioner's guide/flow chart is developed, on how to respond to potential cases of domestic abuse and sexual violence. It is vital staff have the right information to make decisions and are clear about their roles and responsibilities.

10.29 There was little evidence with regard to dual diagnosis. Neither Mr Smith's **[redacted]**, nor his **[redacted]** dependency, was interlinked, with the focus of his treatment on his **[redacted]** dependency. The impact on his overall wellbeing may have been reduced if his **[redacted]** and **[redacted]** had been treated jointly. DAAT have offered and are delivering a training programme to treatment providers in dual diagnoses. The DAAT IMR highlighted the need for a review and development of a local multi-agency dual diagnosis strategy, with agreed pathways and protocols in place, supported by training, with also a conflict resolution process. The Commissioners of Mental Health in Cornwall (NHS Kernow) are acknowledged as the most appropriate agency to set up a working group, which should include the AMHS Organisation and **[redacted]**, to drive this recommendation forward. The new strategy should highlight that a 'dual diagnosis' of alcohol/substance misuse and depression, should automatically result in clients being asked about relationship problems and domestic violence and abuse.

10.30 The LGBT Organisation should review their policy in relation to making follow up contact with clients. Also, Mr Smith's frequent contact with Registered Social Landlord 1 and Mr Barnes's lack of contact with Registered Social Landlord 2 has highlighted the need for the Registered Social Landlord (RSL) Group in Cornwall to consider reviewing their processes for identifying and managing potentially vulnerable customers and those at risk and the implementation of a frequent caller policy. Whilst both RSL's in this DHR have introduced a number of positive initiatives, the DHR Panel believes this recommendation should be considered and adopted by the whole RSL Group and subject to a later audit regarding compliance. The RSL Group should also be part of multi-agency work on domestic violence and abuse and also on hate crime. The SCP is best placed to ensure this happens.

10.31 Arising from this DHR and its specific themes, the DHR Panel asked that the Commissioners for: Cornwall Council (Education, Health and Social Care); Cornwall Community Safety Protection Team; NHS England; NHS Kernow and Dorset, Devon and Cornwall Rehabilitation Company, develop standard service specifications for providers in relation to: Contributing to Domestic Homicide Reviews; Being able to identify, risk assess and refer(where appropriate) cases of domestic violence and abuse; Guidance for the implementation of Routine Enquiry and also that Commissioners should negotiate this inclusion in existing contracts and identify standard text in future tendering opportunities.

10.32 This has been included in this DHR Action Plan as a recommendation to be taken forward by the SCP. Stipulating such requirements, within contract arrangements with providers, is regarded as an effective way to ensure compliance of the key issues. Audit compliance could be through contract management. This recommendation should help to enhance the quality of service to service users. **(Recommendation at page 30, paragraph 11.21).**

10.33 At a national level, the DHR Panel believe there are four areas which required further consideration by the Home Office Violent Crime Unit. Firstly, it is important, where relevant, that learning from all Domestic Homicide Reviews should be shared with both Local Safeguarding Children's and Adult's Boards. This is so as to try and alter the cyclical nature of some of these events. Secondly, this DHR was delayed due to NHS England not being able to gain access to relevant information. All Health partners need to appreciate information should be shared in a timely fashion. Thirdly, the comment by the sentencing Judge that the case was not a domestic incident and could not be categorised as such, may indicate a potential training matter for the Judicial College. The comment was highlighted by the Home Office DHR Quality Assurance Panel and it is the view of the DHR Panel this was a domestic incident. Finally, it is clear the police have made great efforts since **[redacted]**, to create links with the LGBT community. However, it is suggested that we still need to know more about the attitudes and approach by front line police officers and police staff, to domestic violence and abuse in LGBT relationships. It is proposed that HMIC should consider carrying out an

inspection into the policing of domestic violence and abuse in LGBT relationships.

10.34 A very important aspect of this DHR has been to ensure the three questions raised by Mr Smith's family have been answered. The DHR Panel are confident that this DHR has sought, obtained and reviewed all relevant information to establish the answers to the questions. The answers are briefly summarised again now.

10.35 In terms of the police decision to caution Mr Barnes for the offence of false imprisonment in April **[redacted]**, this DHR has shown, given the serious nature of the crime, the CPS should have been consulted and involved in the charging decision. It is the view of the DHR Panel that Mr Barnes should have been prosecuted.

10.36 With reference to risk assessments and levels of community based supervision of Mr Barnes from February **[redacted]** through to June **[redacted]**, this DHR has shown he was effectively managed under the Care Programme Approach, up until September **[redacted]**, when he was discharged from the secondary care AMHS Organisation. After that time Mr Barnes was managed through his GP Practice in primary care. It would have been good practice for Mr Barnes to have been given a face to face assessment in April **[redacted]**, which could have afforded the opportunity to gain an up to date assessment of his mental health and any potential risk. However, in April **[redacted]**, it was highly likely that Mr Barnes would not have met the threshold for the secondary care AMHS Organisation. Today, it is also most likely he would not have met the threshold and would have been dealt with through his GP Practice. It is of note at his mental health assessment on **[redacted]**; no mental health disorder was detected.

10.37 Lastly, with reference to the involvement of Mr Barnes's GP/GP Practice and **[redacted]**/their awareness of Mr Barnes's history, the NHS England IMR details **[redacted]** entries from his GP notes. It remains unclear as to exactly when the main GP knew of the false imprisonment incident. This is due in part to the passage of time and also due to the fact that some of Mr Barnes's medical notes may have been misfiled, but again this is unclear. It is of note however that whilst there are detailed notes, letters etc., described in the IMR from the GP Practice, in relation to the specific period February **[redacted]**, through to June **[redacted]**, there is nothing recorded.

10.38 If the AMHS Organisation had sent a discharge letter from **[redacted]** to the GP Practice after the false imprisonment incident, it would have been expected to be documented in Mr Barnes's GP notes. There was an AMHS Organisation letter of **[redacted]**, which referred to Mr Barnes as 'previously held **[redacted]** hostage', so this may be the first time the GP or GP Practice knew. This is something again which may never be known. The DHR Panel believes Mr Barnes's GP Practice and in particular his main GP, provided Mr Barnes with a consistent level of care.

10.39 Having had the opportunity to go through the original draft overview report with his mother Joyce, the following comments were made by Tony, on behalf of Mr Smith's family:

> 'We just want to say it's fantastic the way you have gone into this review in such depth. As far as we are concerned you have been able to thoroughly answer all the questions we asked of you. We are very happy with the review that has been done. Thank you and the team for all your hard work. We have no issues with the GP's at the time, but still feel there were failings at the beginning when he was arrested and admitted to **[redacted]**. The Mental Health Services shouldn't have dealt with him as a victim. He was treated as a victim rather than someone who committed a serious crime. The nature of the crime beggars belief he was not charged and sent to prison. If he had been prosecuted he would have been monitored when released. The police didn't refer it to the CPS. We are shocked that they didn't prosecute given the severity of the crime. It is of some comfort to us that things are done differently now a day's. We are reassured there are processes in place to stop people like him falling through the system and it happening to others. After reading the report we can now see that services provided are considerably more robust than they were at that time in **[redacted]** and we welcome the action plan and look forward to its outcome.'

10.40 Having also now had the opportunity to go through the revised draft overview report, the following comment was made by Tony, on behalf of Mr Smith's family:

> 'I appreciate how thorough you have been and I'm glad that something good will come of it'.

10.41 It is evident that Mr Smith's family acted with great dignity following the death of Mr Smith. This is acknowledged by this DHR Panel, as is the invaluable contribution they have made to the DHR. The sentencing Judge said, Mr Smith was 'a much loved and missed man'. Mr Smith's family should draw some comfort from the fact that this DHR and the DHR Action Plan will help towards preventing domestic violence and abuse homicide and improve services for all domestic violence and abuse victims and their children.

11 Recommendations

Single Agency

Devon and Cornwall Police

11.1 Devon and Cornwall Police to carry out an audit to establish if prosecution advice files, containing allegations of indictable only offences, are being referred to the Crown Prosecution Service for a charging decision.

11.2 Devon and Cornwall Police to take account of recommendations 1, 2, 4, 6 and 10 of the HMIC 2014 report on 'Devon and Cornwall Police's approach to

tackling Domestic Abuse'; to review the SODAIT Training Plan to establish whether team members, as part of their continued professional development, can receive additional training in respect of increased understanding of 'specialist' groups e.g. LGBT and older male victims; and establish whether domestic violence and abuse incidents involving members of LGBT communities and particularly older male victims, could be introduced into the Police Training Programme, for all police officers and police staff from call handlers to responders.(Any training should include understanding of the nature and dynamics of domestic violence and abuse as a pattern of coercive controlling behaviour and involve specialist LGBT domestic violence and abuse agencies/trainers).

Adult Mental Health Services (AMHS) Organisation

11.3 AMHS Organisation to consider how pertinent risk information held in **[redacted]** for service users who are not on **[redacted]**, is easily available to clinical staff, if the service user is re-referred to Adult Mental Health Services.

11.4 AMHS Organisation to ensure staff complete two day ACPO DASH Awareness/Risk Assessment training, as commissioned by Safer Cornwall Partnership between 2014 and 2016, followed by a structured roll out of 'Routine Enquiry into Domestic Violence and Abuse' in appropriate mental health services, to ensure staff are able to identify, risk assess and refer where appropriate, high risk cases of domestic violence and abuse.

NHS England

11.5 All GP surgeries in Cornwall should receive the IRIS training and use the IRIS approach, if they have not already done so, to ensure that they are equipped to carry out domestic violence and abuse enquiry with female and possibly male patients.

11.6 Medical Director NHS England to be invited to act as a champion for the proposal that South West Peninsula Postgraduate Medical Education considers reviewing their GP curriculum in relation to Domestic Violence and Abuse and the Mental Capacity Act 2005.

Cornwall and Isles of Scilly Drug and Alcohol Action Team (DAAT)

11.7 DAAT to offer provision of staff training to treatment providers in dual diagnoses.

NHS Kernow

11.8 NHS Kernow (Commissioners of Mental Health) to set up a working group to review and progress a local dual diagnosis strategy, pathways and protocols, supported by training, with also a conflict resolution process.

LGBT Organisation

11.9 The LGBT Organisation should review their policy in relation to making follow up contact, in particular with regard to safety of those concerned.

Multi-Agency (Safer Cornwall Partnership)

11.10 Safer Cornwall Partnership to ensure agencies incorporate the NICE Guidelines and recommendations [PH50]: (Domestic Violence and abuse: multi-agency working, 2014), as they relate to training, multi-agency working and 'routine enquiry'.

11.11 The two day ACPO DASH Awareness/Risk Assessment and 'Routine Enquiry into Domestic Violence and Abuse' training, as commissioned by Safer Cornwall Partnership (SCP) to statutory and voluntary organisations, between 2014 and 2016, to have appropriate reference to Domestic Violence and Abuse within the LGBT community, including older people to ensure staff are able to identify, risk assess and refer (where appropriate) high risk cases of domestic violence and abuse.

11.12 The Cornwall Voluntary Sector Forum 'Equality and Diversity' Sub Group to scope any specialist LGBT services and offer the two day ACPO DASH Awareness/Risk Assessment and 'Routine Enquiry into Domestic Violence and Abuse' training to those groups and scope any LBGT services that are willing to provide LGBT awareness training to non LGBT specialist agencies.

11.13 Safer Cornwall Partnership to review: a) How additional update awareness training information can be delivered to those agencies (and the police) who have already undertaken the two day training: b) When best to incorporate it into the current training programme from an agreed point; c) How any potential LGBT awareness training can be delivered by LGBT services to non LGBT specialist agencies. The training should include understanding of the nature and dynamics of domestic violence and abuse as a pattern of coercive controlling behaviour and have reference to the NICE Guidelines and recommendations [PH50]: (Domestic Violence and abuse: multi-agency working, 2014), which provides different levels and types of training for staff working in different areas of the Health Sector.

11.14 Safer Cornwall Partnership to ensure that there are multi-agency networks that include direct links between the health services and specialist domestic violence and abuse services providing support to victims and perpetrators. Distinguishing between domestic violence and abuse victims and perpetrators is complex and should be carried out by specialist domestic violence and abuse experts, rather than clinicians.

11.15 Cornwall Local Safeguarding Children's Board with, support from Safer Cornwall Partnership, to consider reviewing the South West Child Protection Procedures in relation to Domestic Violence and Abuse and Cornwall Local Safeguarding Adults Board, with support from Safer Cornwall Partnership, to consider reviewing the Cornwall and Isles of Scilly Multi-Agency Safeguarding Adults Policy, in relation to Domestic Violence and Abuse.

11.16 Safer Cornwall Partnership to develop a multi-agency practitioner's guide/flow chart on how to respond to potential cases of Domestic Abuse and Sexual Violence.

11.17 Safer Cornwall Partnership to develop multi-agency guidance for GP's on working with frequent service users who present with the 'Toxic Trio'.

11.18 Cornwall Council Domestic Abuse and Sexual Violence Strategic Group to review the findings of the LGBT Organisations **[redacted]** survey **[redacted]** to identify any themes.

11.19 Safer Cornwall Partnership to ensure the Registered Social Landlord Group in Cornwall is part of multi-agency work on domestic violence and abuse and also on Hate Crime.

11.20 The Registered Social Landlord Group in Cornwall to consider reviewing their processes for identifying and managing potentially vulnerable customers and those at risk, including consideration of a frequent caller policy.

11.21 Commissioners for: Cornwall Council (Education, Health and Social Care); Cornwall Community Safety Protection Team; NHS England; NHS Kernow and Dorset, Devon and Cornwall Rehabilitation Company, to develop standard service specifications for providers in relation to: Contributing to Domestic Homicide Reviews; Being able to identify, risk assess and refer(where appropriate) cases of domestic violence and abuse; Guidance for the implementation of Routine Enquiry and for Commissioners to negotiate inclusion in existing contracts and identify standard text in future tendering opportunities.

National

11.22 Where relevant, learning from Domestic Homicide Reviews, is routinely shared with Local Safeguarding Children's Boards and Local Safeguarding Adults Boards, to facilitate an early approach to alter the cyclical nature of some of these events.

11.23 The Home Office Violent Crime Unit and the Medical Director of the General Medical Council to resolve consent issues, pertaining to engaging and sharing information in a timely way, for the purposes of contributing to Domestic Homicide Reviews, so as to minimise any unnecessary disputes or delays.

11.24 The Home Office Violent Crime Unit to raise a potential training matter with the Judicial College, concerning the Trial Judge's sentencing comments that Mr Smith's murder was not a domestic incident and could not be properly categorised as such.

11.25 The Home Office Violent Crime Unit to request HMIC to carry out an inspection into the policing of domestic violence and abuse in LGBT relationships.