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Safer South Tyneside

Domestic Homicide Review

OVERVIEW REPORT

Into the death of Jessie

DHR Case Reference 001

Anonymised for publication and dissemination

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Section One: PREFACE

1.1 Domestic Homicide Reviews (DHRs) came into force on 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

(a) A person to whom he/she was related or with whom he/she was or had been in an intimate personal relationship or;

(b) A member of the same household as himself/herself, held with a view to identifying the lessons to be learnt from the death.

1.2 Throughout the report the term "domestic abuse" is used in preference to "domestic violence".

The purpose of a DHR is to:

- 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;
- 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;
- Apply these lessons to service responses including changes to policies and procedures as appropriate, and identify what needs to change in order to reduce risk of such tragedies happening in the future; to prevent domestic homicide, and to improve service responses for all domestic abuse victims and their children through improved intra- and inter-agency working.

1.3 Subjects of the review

Jessie	Age: 24	Deceased	Date of Death: 2013
Aaron	Age: 32	Perpetrator	Convicted: 2014

Both the victim and perpetrator are of White British origin.

1.4 This Domestic Homicide Review (DHR) examines the circumstances surrounding the sudden unexpected death of a female in South Tyneside. The review was initiated by the Chair of the South Tyneside Community Safety Partnership in compliance with the legislation. The review process followed Home Office Guidance. The names of the victim and perpetrator have been anonymised for the purpose of this report. The family of the deceased chose the name of 'Jessie'. The perpetrator confirmed that he did not have a preferred name to be used in the DHR report.

1.5 DHRs are not inquiries into how the victim died or who is to blame. In the case of Jessie, this was for the coroner and criminal courts to determine.

1.6 The Independent Chair and Overview Report Author and the DHR Review Panel members offer their deepest sympathy to all who have been affected by this death, and thank them, together with others who have contributed to the deliberations of the Review, for their time, patience and co-operation.

1.7 The Independent Chair and Overview Report Author would like to thank all of the members of the Review Panel for the professional manner in which they have conducted the review, and to the Individual Management Review (IMR) authors for their thoroughness, honesty and transparency in reviewing the conduct of their individual agencies.

Section Two: Domestic Homicide Review Panel

Agency	Job Title
Independent Chair and Overview Report Author	Strategic Lead – High Impact Families, South Tyneside Council
South Tyneside NHS Foundation Trust	Strategic Lead Safer Care
NHS England	Quality and Safety Manager (Cumbria and North East)
NHS South Tyneside - Clinical Commissioning Group	Head of Safeguarding
Public Health – under South Tyneside Council since 1st April 2013	Director of Public Health
Northumberland Tyne and Wear NHS Foundation Trust – Mental Health Trust	Head of Safeguarding and Public Protection
Northumbria Police	Detective Chief Inspector
Northumbria Community Rehabilitation Company (Formerly Northumbria Trust)	Director of Offender Management Gateshead and South Tyneside
Impact Family Services	Options Coordinator
Children, Adults and Families – South Tyneside Council	Head of Children and Families Services Service Manager – Mental Health and Learning Disabilities
South Tyneside Homes Homefinder – Homeless Team	Tenancy Services Manager
Changing Lives	Assistant Director
Community Safety Partnership	Area Crime and Justice Coordinator
Community Safety Partnership	Community Safety Officer and Domestic Violence Coordinator
HMP Kirklevington	Head of Offender Management
Department Work and Pensions Jobcentre Plus	Senior External Relations Manager

Section Three: Introduction

3.1 This Overview Report of the Domestic Homicide Review (DHR) examines agency responses and contact with the victim 'Jessie' and with the perpetrator, Aaron, prior to the death of Jessie.

3.2 South Tyneside covers 64 sq. km and includes the towns of South Shields, Hebburn and Jarrow and the villages of Boldon, Cleadon and Whitburn. The borough has a population of 148,100. South Tyneside sits within the Tyne and Wear conurbation – boundaries include the River Tyne and the North Sea.

3.3 At 11.00 hours, on the date of Jessie's death, Northumbria Police were called to the home of Jessie and her partner Aaron. Police forced entry and there found the body of Jessie who was pronounced dead at the scene.

3.4 Three days after the discovery of Jessie's body, Northumbria Police formally notified South Tyneside's Community Safety Partnership of the circumstances of the death and that they believed this to be a domestic homicide.

3.5 The circumstances surrounding this death fit the criteria of a Domestic Homicide Review as Jessie was killed by her intimate partner (Aaron) who resided at the same property.

3.6 Aaron was arrested and subsequently charged with her murder.

3.7 In late 2014, Aaron pleaded guilty to manslaughter by reason of diminished responsibility and was sentenced to life imprisonment with a minimum term of 20 years. The Judge concluded that Aaron is a 'lethal risk to society'.

3.8 Police enquiries have determined that there were no other persons involved.

Section Four: The Review Process

4.1 A meeting of the Initial Core Group was held ten days after Jessie's death, attended by members of the Multi Agency Risk Assessment Conference (MARAC) It was agreed that the case met the criteria for a Domestic Homicide Review (DHR) under section 9 of the Domestic Violence Crime and Victims Act 2004.

4.2 The Chair of the Community Safety Partnership Board was notified on that day that the homicide did meet the DHR criteria and the Home Office were notified within 12 days of the homicide that a DHR would be taking place.

4.3 The Independent Chair and Overview Report Author, Jill Holbert, is the Strategic Lead for High Impact Families - Children, Adults and Families, South Tyneside Council.

4.4 Jill Holbert has twenty-eight years' experience in Children, Adults and Families working within local government. Jill has held a range of senior posts within six different local authorities. She holds a Social Work qualification and a Master's Degree in Leadership and Integrated Services.

4.5 The Community Safety Partnership was satisfied that the Chair was appropriately experienced and independent. While the Chair's employer, South Tyneside Council, had some limited involvement with wider family members, there was no direct or indirect involvement with either the victim or the perpetrator. Neither had been open cases to Children and Families Social Care, nor were either of them referenced during other family member involvement.

4.6 The Independent Chair and Overview Report Author met with the Police Senior Investigating Officer to ensure that the DHR Review process did not conflict with criminal investigation process.

4.7 Agencies known to have had contact with the victim or alleged perpetrator were contacted and asked to secure records, and were advised that a DHR was taking place.

4.8 Agencies were asked to provide a chronological account of their contact with the victim and perpetrator in the period leading up to the death of Jessie.

4.9 Tyne and Wear Fire and Rescue (TWFRS) confirmed that they did not attend the home of the victim and perpetrator for any purpose including Home safety checks or to attend to emergency incidents. Home safety checks had been carried out by partner agencies, and no referrals from partners or other agencies were made to TWFRS as a result of these.

4.10 On 22nd November 2013 an initial briefing session was held for IMR authors. The first DHR Review Panel took place on the 29th November 2013 to agree

the Terms of Reference for the review, and to confirm which agencies were to undertake Individual Management Reviews (IMRs).

4.11 At the start of the review process the families of both the victim and perpetrator were contacted and informed that a DHR would be taking place, and advised that they would be contacted after the conclusion of the trial.

4.12 Individual Management Reviews were completed by the following agencies:

- South Tyneside Clinical Commissioning Group (CCG) on behalf of G.P. Practice
- Northumbria Probation Trust
- Northumbria Police
- Northumberland, Tyne and Wear NHS Foundation Trust
- South Tyneside NHS Foundation Trust
- HMP Kirklevington Grange
- South Tyneside Homes including Homefinder
- South Tyneside Council incorporating; Children, Adults and Families and Public Health
- Changing Lives
- Impact Family Services
- North East Ambulance Service
- Newcastle City Council – Directorate for Wellbeing, Caring and Learning
- Jobcentre Plus

4.13 The time period covered by the review was from September 2006 until September 2013. It was acknowledged that this was a broad time-span, but was agreed as necessary in order to understand the unusual circumstances of how Jessie came to be in a relationship with Aaron while in custody and subsequent events, up to the death of Jessie.

4.14 Each agency's IMR covers the following:
A chronology of interaction with the victim and perpetrator; what was done or what was agreed; whether internal procedures were followed; and conclusions and recommendations from the agency's point of view to address those issues set out in the DHR Terms of Reference. The accounts of involvement with the victim and/or perpetrator cover different periods of time, but are within the scope of the review, prior to the victim's death.

4.15 Some of the accounts have more significance than others. The quality of IMRs, the extent to which the key areas have been covered, and the format in which they have been presented, varies between agencies.

4.16 The DHR Review Panel met on 13 occasions in total, to discuss and review agency IMRs and to agree the final report.

Section Five: Parallel Reviews

5.1 A Coroner's Inquest also took place into the death and the Coroner was notified that the DHR was taking place.

5.2 As Northumbria Probation Trust had significant contact with Aaron leading up to the homicide, this case was also subject to a Serious Further Offence Review for the Ministry of Justice. The IMR author for Northumbria Probation Trust incorporated further relevant information emerging from the Serious Further Offence Review into their IMR, for the purposes of informing the DHR. A summary report of this review has also been shared with the victim's family.

Section Six: Timescales

6.1 The Criminal Investigation commenced at the time of Jessie's body being discovered and concluded in late 2014.

6.2 The decision was made to run the DHR process in parallel to the criminal investigation to avoid risk of delay in agency learning. Victim, family and some staff interviews could not commence until after the conclusion of the trial.

6.3 The Community Safety Partnership communicated delays in the trial to the Home Office and therefore timescales for the review were adjusted accordingly.

6.4 The DHR was completed within six months of the trial conclusion date, in line with Home Office guidelines

Section Seven: Confidentiality

7.1 The findings of this review are restricted. Information is available only to participating officers/professionals and their line managers, until after the Domestic Homicide Review Overview Report has been approved for publication by the Home Office Quality Assurance Review Panel.

7.2 Signed consent was obtained from Aaron for access to all confidential records relating to him.

7.3 All Review Panel members signed a confidentiality agreement.

Section Eight: Dissemination

8.1 Each of the Review Panel members has received a copy of the Domestic Homicide Overview report. The report will also be shared with the victim's family, the perpetrator, and the perpetrator's family, prior to publication. Members of South Tyneside's Community Safety Partnership received copies of the report for discussion and approval at an Extraordinary Community Safety Partnership meeting.

Section Nine: Contributors to the Review

9.1 The DHR Review Panel consisted of senior officers of the statutory and non-statutory agencies listed in section 2 of this report, who were be able to identify lessons learnt and to commit their organisations to setting and implementing action plans to address those lessons. None of the members of the Review Panel or any of the Independent Management Review (IMR) authors have had any direct contact with either the victim or perpetrator. Voluntary Sector involvement on the Review Panel has been sought through the inclusion of Impact Family Services, who provide support to victims of domestic abuse, and of Changing Lives, who provide tenancy support.

9.2 In this case 14 organisations completed Individual Management Reviews. The IMRs and reports have been thorough, honest and transparent.

9.3 Following the Transforming Rehabilitation Agenda in June 2014, Northumbria Probation Trust underwent significant changes and was reformed as two separate different organisations; National Probation Service, and the Northumbria Community Rehabilitation Company (NCRC). As this occurred part-way through the review process, the membership of the panel only included NCRC).

9.4 The Review Panel has had sight of three Independent Psychiatric Reports which were prepared for the purpose of the criminal trial.

9.5 The Independent Chair and Overview Report Author would like to thank Dr. James W. A. Stoddart, Consultant Forensic Psychiatrist; Dr. M. J. Tacchi, Specialist Field, Psychiatry; and Dr. Kim E. Page, Consultant Forensic Psychiatrist, for giving their permission for these reports to be considered as part of the review process and for these to be quoted from, within the Domestic Homicide Review Overview Report.

9.6 The families of both the victim and person charged with the homicide were contacted and informed that a Domestic Homicide Review would be taking place at the start of the review process. The families of both the victim and perpetrator have been consulted by the person acting as Independent Chair and Overview Report author, during the preparation of this Overview Report.

9.7 Four of Jessie's friends were also consulted as part of this review.

9.8 The perpetrator was also interviewed by the Review Panel Chair as part of this review process.

9.9 The person acting as Independent Chair and Overview Report Author of the review has had sight of all Police witness statements.

9.10 The Parole Board also submitted information for the purpose of the review.

Section Ten:
Family, Friends, Significant Others Involvement

10.1 The Independent Chair and Overview Report Author explained to all those interviewed that the purpose of the DHR was to identify any lessons that agencies can learn from Jessie's tragic death, to try to prevent a similar tragedy from occurring in the future.

10.2 The Independent Chair and Overview Report Author explained to all interviewed that those people closest to the victim often have valuable information that agency records do not contain, but which is essential to the review process in trying to answer questions. The Chair offered the deep sympathy of the Review Panel members, and thanked the family and friends for their participation in the review process.

10.3 All of the following are based on accounts given by those interviewed, and therefore there may be some conflicting information. The Review Panel has made no judgements on the information provided.

10.4 Meeting with Victim's Mother

10.4.1 The Independent Chair and Overview Report Author went out to meet the victim's family, and was introduced by the Police Family Liaison Officer. The Chair had previously written to the family to explain the purpose of a Domestic Homicide Review, and had issued a copy of the Terms of Reference.

10.4.2 Jessie's mother described her as having "a heart of gold", and as "someone who would do anything for anyone". She said that she knows that mothers would usually say this about their daughters, but in this case it was true, and that anyone who knew Jessie would say the same. She spoke of the love she had for her family, and of how close they were.

10.4.3 Jessie visited the family home most days, and Aaron would often be with her.

10.4.4 Jessie's mother remembered Jessie telling her that she had been introduced by a friend to Aaron, and that he, Aaron, was in prison custody. Jessie had told her that he had been involved in a fight, and that someone had been killed, but that Aaron had not been the one that killed him. She stated that she had been apprehensive at first, but that when she met Aaron, he "just looked so young and like he couldn't possibly harm anyone".

10.4.5 In relation to the previous offence disclosure, mother was very upset and angry with the probation service, as she felt she had not been made aware of the full facts about the level of violence involved in the offence, and that a knife had been used. She stated that the Offender Manager had visited, and had asked what they had been told about Aaron's offence. She remembered explaining her understanding of the circumstances of the fight, and that Aaron was not the person who had killed the victim. She said that the

Offender Manager had confirmed that this was the case. She said she had felt as though it were their family who were being scrutinised, to see whether they were suitable for Aaron. She had responded with something to the effect that everyone deserves a second chance. She stated that Aaron was not present at the disclosure, and she had not met Aaron at that point, nor had he been to their home.

10.4.6 She remembered Jessie trying to look up details of Aaron's previous crime on the internet. Jessie could not find anything, and believed that this was linked to his being a juvenile at the time.

10.4.7 She had never observed or had any reason to suspect any domestic abuse in the relationship, and felt she would have known if this were the case. She described the relationship which Jessie and Aaron had as being very close, as a loving relationship, and that they always seemed happy together. She recalled an occasion when they had been riding on a bike, happy and laughing.

10.4.8 Jessie worked at the café of an extended family member, and also worked with Aaron's sister at the racecourse on race days and events. She was always hard-working.

10.4.9 In relation to Aaron, she described him as having 'Obsessive Compulsive Disorder' (OCD) characteristics, "always taking things apart and getting fixated on things".

10.4.10 She was aware that Aaron misused Subutex, and stated that Jessie sometimes used to get this for him, because of his exclusion zone. She said that sometimes she offered to go and collect this for Jessie, as she was worried about Jessie going on her own.

10.4.11 In the days leading up to Jessie's death, Jessie had contacted her about her concerns over Aaron's strange and erratic behaviour, and his difficulty in sleeping. Mother had not known how to help, but had given Jessie information on a medication for Bipolar Disorder, and suggested that she look this up on the internet, to see if it might help.

10.4.12 After Jessie's death she found a paper copy of a housing application form. Although Jessie had never discussed this, her mother suspected that her motivation for applying for a property was because Jessie did not want to live in a house with cannabis growing in it.

10.4.13 The family had been devastated by Jessie's death and their grief, loss and suffering was beyond words. The Independent Chair and Overview Report Author offered her deep sympathy on behalf of the members of the Review Panel. The family were offered support in accessing services that might help with their grief and loss, and details of 'Advocacy After Fatal Domestic Abuse' (AAFDA) were given to the family.

10.4.14 Jessie's mother expressed that she wanted someone to come and take away the guilt and pain they were experiencing. She felt that had she known and understood more about Aaron's previous conviction, she could have talked to Jessie and tried to advise against the relationship. She asked the Review Panel to consider the following four questions:

- Why probation services did not tell them of the full extent of Aaron's previous offence, including weapons used and level of violence;
- Why Social Services did not intervene following Jessie's booking with midwifery services, given Aaron's background;
- Why Social Services allowed someone with Aaron's background to be allowed to stay overnight and to spend time in a house where children were present;
- Why the G.P. did not do more when Jessie went into the surgery the day prior to her death;

10.5 Meeting with friends 1 & 2 of the victim

10.5.1 The friends were nominated by Jessie's mother. The Independent Chair and Overview Report Author therefore made contact with them by letter and telephone, and they asked to be seen together. The meeting took place at one of their homes in South Tyneside.

10.5.2 Friend 1 had met Jessie through her older sister whilst they were still at school, and they had maintained a friendship ever since. Jessie usually visited fortnightly. She described how Jessie was "lovely and brilliant with kids" and used to help her bathe and put the little one to bed.

10.5.3 Friend 2 had met Jessie through a mutual friend. They had remained friends, but contact over recent years had been through 'Facebook.'

10.5.4 Friends 1 and 2 had accompanied Jessie to the first arranged meeting with Aaron. Jessie had been writing to another lad in prison, and it was this person who had introduced her to Aaron. He had told Jessie that he was in prison for manslaughter, following a fight where someone had been 'killed'. Friends 1 and 2 described Aaron as a "canny lad."

10.5.5 Jessie had never disclosed any domestic abuse between her and Aaron to friends 1 and 2, and they were both totally shocked by what had happened. Jessie had mentioned minor arguments, and said that Aaron used to smash her ashtrays. Friend 1 said Jessie used to laugh about it and say she was fed up of having to keep buying new ashtrays. They also recalled an incident where Aaron had asked Jessie if she would wash and iron a shirt and take it to him, so that he could go out. Jessie had driven to him with the shirt, but he had thrown this back into the car and said that it was the wrong shirt. Jessie had sworn at him, and driven off. Friends 1 and 2 believed any arguments between the couple were routine, and felt that Jessie was able to stand her ground with Aaron.

10.5.6 Jessie had disclosed to friend 1 that Aaron used drugs ("Subbies").

10.5.7 Friends 1 and 2 said Jessie had told them about an argument with one of Aaron's sisters on his Birthday, and that they felt that Jessie did not have a good relationship with this sister as a result of this.

10.6 Meeting with friends 3 & 4 of the victim

10.6.1 Friend 3 was nominated by Jessie's mother. The chair contacted friend 3 by telephone and arranged an interview; friend 4 accompanied her.

10.6.2 Friends 3 and 4 both worked at the café in which Jessie was employed and worked, from 11.00am – 2.00pm daily. They had worked together for approximately 2-3 years. They said that Jessie had another job, working at the Racecourse on race days, mainly on a Saturday. They described Jessie as "bubbly, well liked, helpful and never off work."

10.6.3 Aaron used to collect Jessie from work and would give them a lift home. They always found him to be polite and said they got on with him.

10.6.4 Jessie had told them that he had been in prison for 12 years, due to his being present when his friend killed someone. She hadn't seemed concerned by this.

10.6.5 Friends 3 and 4 said Jessie talked openly about wanting a baby and the miscarriages she'd had. They said Jessie kept some Tramadol in the drawer at work which she took when the pain got bad (stomach pain) but this was not very often. They stated that Aaron didn't want a baby, but they did not know the reason for this.

10.6.6 Neither could believe what had happened, as they thought the couple had a very close relationship. They were not aware of any domestic abuse. Jessie used to laugh and say that she got on Aaron's case when he put his food waste into the toilet and washed his plate in the bathroom sink.

10.6.7 Jessie had told friends 3 and 4 about an argument with one of Aaron's sisters in the weeks leading up to her death, linked to the Police finding out about an associate growing cannabis.

10.6.8 A couple of weeks before her death, Jessie had begun asking friend 3 about how to bid on properties. Jessie had wanted to live nearer to her mother and family. She had said that it was optional if Aaron chose to move with her, or stay. They described Jessie as 'strong-willed'.

10.6.9 On the Monday prior to Jessie's death they said that Aaron had been due to start a college course, but then Jessie found out he had not turned up for this.

10.6.10 Jessie had come into work on that Monday and the next day, Tuesday, and had talked about Aaron not sleeping and being obsessed with his telescope, stars and planets. Jessie had been laughing, not taking him seriously, and

calling him an idiot. However, on the Wednesday they noted a significant change in her, describing her as upset and anxious.

10.6.11 On the Thursday morning, Jessie had been dropped off at work by two of her sisters. They said that she was crying and emotional, because she had woken up to find Aaron praying over her, and saying that God had chosen him. She had spoken with her boss, who allowed her to leave work to try to arrange a doctor's appointment for Aaron. They believe that Jessie then contacted her sister to pick her up and take her home.

10.6.12 Friend 3 said she had received a text from Jessie just before 10.00pm on the evening before her death, asking her to tell their boss that she wouldn't be at work the next day, and that Aaron had not gone to see the Doctor.

10.7 Meeting with perpetrator's mother

10.7.1 After the conclusion of the trial, the Chair wrote a follow up letter offering an opportunity to meet. The perpetrator's mother responded to this, and a meeting was arranged.

10.7.2 The perpetrator's mother was very upset by what had happened to Jessie. She stated that she felt that she had "lost both a son and someone (she) viewed like a daughter". She stated that her initial reaction when she had heard what Aaron had done was one of anger, shock and horror. This was before she had known or understood that he was ill. She said they were devastated by what had happened, and could not believe it.

10.7.3 She spoke very fondly of Jessie, and said how much she had done for Aaron since he had come out of custody; she had taken responsibility for paying bills and "kept him right" in attending his appointments with his Offender Manager and Jobcentre Plus.

10.7.4 She stated that they were together all the time, and talked affectionately of an occasion when they both worked together painting a fence. She showed a photograph to the Chair of Jessie and Aaron together, looking very happy.

10.7.5 She stated that Jessie worked with Aaron's sister at the racecourse.

10.7.6 The perpetrator's mother spoke of how close they were as a family and said they had always supported Aaron, making fortnightly visits to him in prisons all over the country whilst he served his previous sentence. His siblings also made regular visits.

10.7.7 When he had first come out of custody, he had an offer of a permanent job working with his step-father in his business. She advised that they had been told that this was not viable, due to the exclusion zone which would be in place.

10.7.8 The exclusion zone had a significant impact on Aaron, as it prevented him from visiting home and isolated him from family members.

10.7.9 They had tried to support him and Jessie by assisting in buying furniture for their home, and had also bought Aaron a car with a view to this improving his job prospects. She stated this had only been an old runabout car, and that although it was a loan, there was no pressure on them to repay this.

10.7.10 She stated that when Aaron had been in prison custody, the Offender Manager had not visited him regularly and did not know him. She stated that prison personnel had once stated in a report that "that Probation would hold him back". She felt that the Offender Manager had been reliant on them for information to include in his reports, and visited them when he had to write one. After release the Offender Manager had no further contact with them in respect of Aaron.

10.7.11 She felt that the Offender Manager that supervised Aaron when he came out of custody would have been more suited to working with victims, as he was more "pro-victim", and less supportive of helping offenders. She remembered Aaron telling her that he had met with the Offender Manager and Jessie, and then with Jessie's mother, and had had to explain his role in, and the details of, the murder offence for which he had been imprisoned. She also recalled that Aaron had a box containing copies of prison and probation reports, which he and Jessie had stored in the loft of their home.

10.7.12 The perpetrator's mother stated that she was completely against drugs, and did not know anything about this until after the death of Jessie. It was only from information that subsequently emerged that she could now make tentative connections, such as the possible significance of Aaron's continual sniffing. She had not previously at any stage been aware that Jessie had taken amphetamines, as subsequently alleged, but described her as having been 'painfully thin' at one stage, and recalled her as having being ill in bed for a period of time. She then noted positive changes in Jessie's appearance, including healthy weight gain, her hair looking shinier, and Jessie generally looking much healthier. She stated that Aaron was at that time telling Jessie to listen to the compliments other people were paying to her, about the positive change in her appearance and how lovely she looked. She now questioned whether the illness had been linked to possible withdrawal symptoms, from having stopping taking amphetamines in order to try to improve her chances of having a baby.

10.7.13 Aaron did not want a baby as he felt that their situation was not suitable, given that he didn't have a job and they were living in a one bedroom flat. At the time of the first two miscarriages, Aaron was still residing in the bail hostel and was subject to monitoring; this restricted him from being at the hospital with Jessie, and may explain why he was not recorded as present. In the weeks leading up to the homicide, Jessie was talking about getting pregnant again, and Aaron could not understand why she wanted to put herself through the risk of miscarrying once more.

10.7.14 She described Aaron as "not being able to sit still for a minute" and as being "on edge" all the time. This was linked to him always feeling he was looking

over his shoulder. She also said that if she telephoned him, he would often respond by asking if one of his sisters or someone had been talking about him.

10.7.15 She said he was always upstairs or outside, messing with technical things and taking them apart, and described him as a perfectionist.

10.7.16 She stated that Aaron did not see the point in looking for a job because he felt that no one would employ him because of his background, and that although he didn't like going to the G.P., he had visited to obtain 'sick note's in order to avoid work training schemes, which he felt were pointless.

10.7.17 After the homicide, Aaron had confided to her that he and Jessie had discussed plans to acquire another property in Jessie's name, as part of a joint decision.

10.7.18 On the morning of the day prior to her death, she that stated her daughter had contacted her to say that she had spoken to Jessie, and that Jessie had asked that she didn't visit, as she was worried that Aaron would then know they had been talking about him. Her daughter had said she was going to visit that evening.

Jessie had then sent Aaron's mother a text later that evening, stating that "*If you see him will you not say anything to him yet*"

Jessie then sent a further text stating
"*he's seriously paranoid so I don't want him to think I've been talking about it. He sat 4 hr messing about with his phone and he's made us promise I wont ask what he's doing or go near his phone or computer. He's saying he's okay and that he has never been happier so I don't really know*."

The perpetrator's mother asked Jessie why she wasn't allowed to go near his phone or computer Jessie replied
"*I don't know he says I have to just trust him and not ask any questions he kept saying he was going to the doctors then acting as it we never talked about it*."

The Chair had sight of these texts which the perpetrator's mother had retained on her mobile phone.

10.7.19 The perpetrator's mothers concluded by saying that she thought that Aaron's G.P. could have taken a contact number, on the day prior to her death when Jessie went to see this doctor to get him help; and also that she wished the G.P. had 'phoned the Police, and had got Aaron the medical help he needed.

10.8 Meeting with Perpetrator

10.8.1 Aaron explained that, following release, he was constantly on edge about the possibility of going back to prison, was concerned about making mistakes, and felt as though he were constantly being watched.

10.8.2 The initial exclusion zone resulted in him being cut off from his family, who had stuck by him during his time in prison. He had no intention of seeing the victim's family. He felt that when the exclusion zone was set, it was unclear whether agencies even knew if the victim's family were still residing in the area. Even when the exclusion zone was reduced, the Offender Manager seemed unclear about where the victim's family were at this point. He felt that this was important, in order to ensure that exclusion zones were relevant.

10.8.3 He very much would have liked to work with his step-dad, but was unable to do so due to the exclusion zone. He reported that although he had raised the issue with his Offender Manager, there was no flexibility, and he could only work outside the exclusion zone. By the time the exclusion zone was reduced, the opportunity for him to gain employment with his step dad had been lost, as this was over five years after his release.

10.8.4 He would have welcomed the structure of work, rather than end up falling into the routine of being lazy. He was used to spending a lot of time alone, as a result of his time in prison.

10.8.5 His Offender Manager and JobCentre Plus were encouraging him to attend work programmes, but he found it very difficult to work in group settings. Such situations would make him very anxious and nervous. He reported that while in a young offender institute, his difficulty with group situations had been identified as a problem, and as a result, a 1-2-1 approach was often taken. However, in adult prison, support was only offered and provided in a group setting. He said that Prison and his Offender Manager were aware of this issue, but was not sure if the level of the problem was understood. He felt that there was too much of a focus on him going on work programmes and getting a job. He didn't necessarily think this was achievable, and felt that his only chance of getting a job was through someone putting a good word in for him.

10.8.6 He was concerned about how he would have coped in a work setting with other people, and felt that it would need to be the correct environment, and be a role in which he was not surrounded by lots of people.

10.8.7 He felt that his G.P. referrals to mental health services were pointless. He had difficulty in going to places, especially new places. He would sometimes use drugs to give him confidence to cope with such situations. He would have found it beneficial to have appointments offered at home, or for someone to go with him. As a result of these difficulties he would often go out more at night, because it was quieter.

10.8.8 Aaron did not feel that the changes in Offender Managers had any negative impact on him. He felt that the first one was very cautious and "dragged things out", which meant that Aaron remained in the hostel a long time before being allowed to have his own accommodation. He also felt that overnight stays were allowed only irregularly, so that he never knew where he stood. However, overall he felt that he had good relationships with them all, and that Probation had probably done everything they could for him.

10.8.9 In relation to having seen multiple staff at the Job Centre, he felt that this meant that generally, no one understood his wider life situation. He recalled one particular member of staff who he felt was good; this was because he had been able to tell them about his situation, and he felt that they understood.

10.8.10 He reported that he didn't receive any support in terms of the practicalities of independent living, and the only support he received about day-to-day living was from Jessie. He stated that she had "taught him everything".

10.8.11 He acknowledged that a support worker could have provided some of that support, but that he didn't engage with them, as it would have taken him some time to build a relationship and to trust them sufficiently. He said it felt false to get that kind of help from someone whose job it was to support him in that way.

10.8.12 He felt it was a lot better to have a system similar to that at Kirklevington, where they had direct links with local employers and were able to offer jobs or placements directly, rather than go on lengthy courses before being able to apply for jobs. He felt that it was very difficult to survive and pay for day-to-day things, in the absence of work related income.

10.8.13 In relation to drug tests, he said that there were ways round urine and swab tests, and that the tests could be better. He did recall having some tests after his release, whilst residing at the hostel.

10.8.14 Regarding his own substance misuse, he stated that he had used drugs for so long that no one would have noticed any change in his behaviour. He stated that he didn't take drugs to "get high", but that he was so anxious and nervous about going out and being with people, he would have "just enough" to get him through the day. He was careful about the amounts of drugs he used, and concealed this use from his family.

10.8.15 He explained that he had started using Subutex whilst he was in prison and had contacts of where to access this from. However, due to his exclusion zone, Jessie offered to get it for him so that he would not get into trouble.

10.8.16 He didn't use cannabis while he was in prison, and was unsure as to why he'd started to use it following his release. He reported that it would mainly be late at night, to bring him down after having used amphetamines. He said he and Jessie would smoke this on an evening. He said he would take the

'cannabis farm' down whenever he knew anyone would be visiting. He was sometimes paranoid and anxious, and so wouldn't answer the door or the 'phone. He didn't want to go back to prison as a result of growing cannabis, but felt that the financial rewards were worth the risk. The income from this was mainly used to pay bills, and not to support any other drug habit. He was worried that if he asked for any help with his drug use, he would have been put back in prison.

10.8.17 In terms of housing, he confirmed that he and Jessie had never spoken about moving house or applying for another property, and that they were content to stay where they were. However, he acknowledged having a baby might have precipitated a move.

10.8.18 Aaron explained that, when disclosure took place, he was already at Jessie's home in her bedroom. When his Offender Manager arrived, he recalled going downstairs and having to explain to her mother the details of the offence, including his role in having hit the victim with a crowbar. Jessie remained upstairs in her bedroom, and only he, the Offender Manager and Jessie's mother were present in the room when the disclosure was made. He said that he had never hidden the reason he had been in prison. He felt that he wanted to be open about it, as it was part of his past. He confirmed that he had previously disclosed details to Jessie. He felt that there was no doubt that everyone understood what had happened and why he had been in prison.

10.8.19 Relating to the miscarriages that Jessie suffered, he explained that he had attended the hospital with her when he could, but had had to return to the hostel at 11:00pm due to his curfew; he would return the following morning. He confirmed that Jessie had first been prescribed Tramadol at the hospital, after miscarrying due to the severe pain she had suffered. He remembered that on one occasion she was admitted at approximately 4:00am.

10.8.20 Aaron said he had gone with Jessie to the G.P. practice for general appointments, although did not go in with her to see the G.P. He also recalled going with Jessie to investigatory appointments and tests with a neighbouring authority, after she had suffered her third miscarriage.

10.8.21 He confirmed that he didn't particularly want a baby, but had told Jessie that it was fine if that's what she wanted. He said that while he would be supportive, he wouldn't have expected to be actively involved in some practical aspects of childcare. He also expressed concerns he had about the possibility of having a child while he was struggling to adjust to life back in the community, and the impracticality of their situation, including poor living accommodation, poor financial situation, and lack of job prospects. He didn't "believe in having a child, if you were unemployed".

10.8.22 He said Jessie's health had been "really, really" bad during her use of amphetamines. He can recall her having low energy and collapsing on occasions, or "conking out", and that her weight was very low. He reported that she had been using amphetamines since a young age. However, he

explained that her amphetamine use had reduced significantly following her first miscarriage, and whilst she would still use it occasionally, her weight had noticeably increased. He felt that this reduction in use was directly related to her wanting to have a baby, and the fact that she blamed herself for the first miscarriage. He explained that she was very frustrated about the miscarriages, and wanted to understand why they were happening. He understood how much they had affected her and how difficult it was for her.

10.8.23 He explained that he'd stopped seeing his G.P. in relation to his mental health as he felt he was coping.

10.8.24 In relation to the events leading up to the homicide, Aaron felt that rather than what had happened, it would've been better if someone had forced themselves into his property and sectioned him as a result of concerns raised. At the time, he thought that he was okay, and could deal with it himself. He reported that he was used to not asking for help, and that this was something that had been reinforced during his time in prison. He explained that he tried to keep his distance from some services, as he just wanted to get on with his life.

10.8.25 He felt that everything had been okay until the weeks leading up to the homicide, and that he could cope with any issues as long as he were either on his own or with Jessie. He added that he was quite introverted as a result of the time he had spent in prison.

10.8.26 After the interview, the perpetrator conveyed a message through his Mother to the Chair, in which he said how sorry he was, and how much he loved and missed Jessie.

Section Eleven: Background

11.1 At the time Jessie met Aaron he was serving a life sentence for murder, which carried a minimum ten-year tariff. The offence was committed with another youth and was an unprovoked attack. Aaron was aged 15 at the time. Both he and his co-accused were sentenced on a joint enterprise basis. Aaron struggled to accept the sentence, and so served a total of 12 years imprisonment.

11.2 Jessie first met Aaron in 2008 whilst he was in custody, placed in an open prison. Aaron was allowed community visits at the time, as part of his resettlement day release. It is believed that they were introduced through another inmate. At the time Jessie was aged 19, and resided with her mother, her mother's partner, two siblings aged 12 and 15 years, older sister, and nephew aged 4.

11.3 Aaron was released from custody in 2008 and resided in approved premises until April 2010. On acquiring his own tenancy Jessie moved in with him, where they lived together until the time of her death. There were no other residents living at the address.

11.4 Information received from Jessie's family and friends is that Jessie worked at a café run by an extended family member and also at the racecourse on event days.

11.5 Three days prior to her death Jessie contacted her mother in tears about Aaron's behaviour, which she described as erratic and strange. Over the following two days a number of telephone and text exchanges took place between Jessie and her Mother, relating to Aaron having problems sleeping and his refusal to see a G.P.

11.6 Two days prior to the death of Jessie, following a visit from her brother, Aaron's sister telephoned Jessie to express concern regarding changes she had observed in his behaviour. Jessie was said to have been relieved to be able to discuss the concerns with someone else who had also noticed the changes.

11.7 At approximately 12:30pm on the day before Jessie's body was discovered, Jessie attended the G.P. Practice where her partner Aaron was registered. She spoke to the receptionist, and asked to speak with someone regarding the concerns she had in relation to her boyfriend, who was a patient at the practice. A G.P. then saw Jessie, who expressed her concerns about her partner's strange behaviour. She explained that he had been watching American conspiracy-theory DVDs, talking constantly and laughing about them. G.P. documentation shows that Jessie said Aaron "was sleeping, but bouncing out of bed"; and the G.P. recorded that they thought Aaron "could be manic to some degree". In a Police statement, the G.P. described Jessie as looking "worried, emotional and upset" by Aaron's erratic behaviour.

11.8 The G.P. made an appointment to see Aaron at 3:00pm the same day, if Jessie could get him to attend. According to the G.P. Police statement, Jessie later called the G.P. Practice to cancel the appointment.

11.9 On the evening prior to the discovery of Jessie's body, the perpetrator's sister visited the couple. They said to Aaron that he really should see a doctor but Aaron said "that he hadn't cracked up and that he would rather go and top himself." Aaron said at one point about Jessie, "she thinks I've cracked up, she's got no faith in us. She thinks I'm gonna top her because I'm happy". She described Aaron as "hyper", fiddling with leads, and going in and out of the bathroom. After going home, Aaron's sister had a text exchange with Jessie, and had telephoned and spoke to both at around 10:00pm before retiring to bed. Aaron told her he "was alright", and Jessie said she "felt safe" and was more worried about him.

11.10 At 8:00am on the day that Jessie's body was discovered, Police received a report of an intruder at a college in a neighbouring authority. Police approached the male intruder, now known to have been Aaron, and found him to be in a confused state and possibly under the influence of drugs. He was arrested on suspicion of driving while unfit through drink or drugs.

11.11 At approximately 9:00am that day, Jessie's sister sent her a text but did not receive a reply.

11.12 On the same day at approximately 9:00am, the sister of Aaron attempted to contact both Jessie and Aaron by telephone, but received no response. After receiving information from her mother that her brother had been arrested, she then visited the home address, but received no response. She then drove with her partner to Jessie's family home, to explain that she was unable to make contact with Jessie and that Aaron had been arrested. Jessie's sister then accompanied them to the café where Jessie worked. After being told Jessie was not in work that day, they returned to the flat where the couple lived. As they did not know the whereabouts of Jessie, they contacted the Police at approximately 11:00am.

11.13 Police attended the address, entered, and found the victim with obvious injuries. She was declared dead at the scene. A number of knives were recovered at the scene, some of which were blood stained.

11.14 The post mortem examination found bruising and abrasions to the neck, bruises to the face, arm and legs, twelve stab wounds to the torso, and two incised wounds to the neck. The death was attributed to a combination of stab wounds to the chest and manual strangulation.

11.15 Aaron was already in Police custody, and was subsequently arrested for her murder.

11.16 Within the bedroom, a tent was found housing a ‘cannabis farm’. Police removed from the scene eighteen cannabis plants, a cannabis leaf, and a halogen lamp.

11.17 Toxicology reports indicate that Jessie was likely to have administered cannabis in relative proximity to the time of her death; however, had she been an habitual user of cannabis, results may not be indicative of recent cannabis use. No use of alcohol was detected.

11.18 Toxicology reports for Aaron indicated the presence of cannabis compounds in blood samples taken from him on the day of his arrest, consistent with recent use of cannabis.

11.19 Three independent psychiatric assessments were carried out on Aaron for the purpose of the criminal trial. The Psychiatric reports were all in agreement of a psychotic disorder; however, there was a differential diagnosis, of schizophrenia, or of acute and transient psychotic disorder.

Section Twelve: Terms of Reference

12.1 The Specific terms of reference for this review were to consider:

- Whether an improvement in internal and external communication and information-sharing between services might have led to a different outcome.
- Whether key opportunities for assessment, decision-making and effective intervention were identified, and were carried out in a timely manner.
- Whether appropriate services and interventions were offered/provided, and/or relevant enquiries made, in the light of any assessments which were carried out.
- Whether agency transition planning arrangements were sufficiently robust.
- Whether issues were escalated to senior management or other organisations and professionals in a timely manner, where appropriate.
- What training practitioners and managers had received, and whether this was sufficient to enable them to carry out their roles effectively.
- What impact did the services provided by each agency have, in identifying and dealing with co-existing factors such as mental health, substance or alcohol misuse, and domestic violence?
- Whether the work undertaken by services in this case was consistent with each organisation's:

  (a) Professional standards

  (b) Domestic violence policy, procedures and protocols.
- Were agency procedures in place and fit for purpose.
- Whether practices by all agencies were sensitive to the nine protected characteristics as defined in the Equality Act 2010.
- If there was a low level of contact with any agencies, were there any barriers to either the victim or the perpetrator accessing services and seeking support?
- Does any agency hold information offered by informal networks? For example, the victim or perpetrator may have made a disclosure to a friend, family member or community member.

- Was there evidence of robust management oversight of the case, including whether practitioners working with either the victim or the perpetrator had received appropriate supervision, and was this of the required frequency and quality.

- Were there issues in relation to capacity, resources or organisational change over the period of the review that impacted in any way on partnership agencies' ability to respond effectively.

Section Thirteen: Domestic Homicide Review Concluding Report

13.1 This report is an anthology of information and facts from participating agencies. It also includes three Psychiatric Reports, from Dr. M J Tacchi, Specialist Field: Psychiatry, Dr. James W. A Stoddart, Consultant Forensic Psychiatrist, and Dr. Kim E Page, Consultant Forensic Psychiatrist; Police witness statements; and information received from the Parole Board.

13.2 The report also includes information gained from the insight of friends, colleagues and family members. All provided information, and some asked questions which the Review Panel and Individual Management Review (IMR) authors included within their deliberations. The family members who engaged with the DHR were consulted by the Independent Chair and Overview Report Author during the course of the Review and preparation of this Overview Report and have had the opportunity to see the final Overview Report.

13.3 **Individual Management Reviews**

- Diversity
  None of the IMRs identified diversity considerations in relation to the nine protected characteristics as defined in the Equality Act 2010; age, disability, race, religion and belief, gender re-assignment, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity.

- South Tyneside has issues of high deprivation, poor health and high unemployment. Given that both Jessie and Aaron were registered with JobCentre Plus, the Review Panel felt that none of the IMRs gave sufficient consideration to wider socio-economic factors such as financial circumstances, social exclusion, educational and skills background, and past criminal convictions, and how these may have impacted on them individually or as a couple.

13.4 Review of IMR prepared by Newcastle City Council - Wellbeing, Care and Learning

- The IMR detailed an extensive history of involvement from Children and Families Social Care with Aaron, from the age of 7 years up to his being sentenced and imprisoned for murder at age 16. The timeframe for this was not within the scope of this review, but did provide significant relevant information in relation to Aaron's background experiences leading up to the original offence of murder. The IMR author was unable to locate a copy of the internal management review, requested by the Director of Social Services after the first charge of murder; therefore it was not possible to gain insight from any learning at that time.
- Due to significant legislative, policy and practice developments between 1988 and 1998 with regard to child protection and youth offending, there

has since been a complete overhaul of systems, and therefore no additional learning could be sought from the IMR.

13.5 Review of IMR prepared by HMP Kirklevington Grange

- Aaron had served his custodial sentence at four different prisons before finally transferring to HMP Kirklevington Grange on 8th January 2007, where he remained until his release on 5th December 2008.

- Initially Aaron was managed at stage 1, with no activities outside of the prison grounds. In March 2007 he progressed to stage 2, commencing supervised escorted activities outside of the prison grounds, moving on to stage 3 by July 2007, when he commenced resettlement day release. His first community work placement was in a charity shop, for which he was released from the prison. During these five days, he could leave prison from 0830 hours, and had to return by 1755 hours. In August 2008, Aaron's resettlement day release visits were extended to include community visits on a weekend day. Between August and October 2007, Aaron had a total of 56 weekend resettlement day release visits. Aaron then commenced work at a public house as a chef's assistant, where he worked until his release.

- In March 2008, Aaron progressed to the final stage of overnight resettlement release, at which time it was agreed that he could stay at an approved premises run by Northumbria Probation Trust. He made a total of five overnight visits between March 2008 and September 2008.

- Between 22nd June 2007 and 24th July 2008 there were 13 intelligence reports relating to the alleged use of substances and a mobile phone. Aaron was subject to three adjudications. On the 30th May 2008 the risk assessment described issues of complacency, deteriorating appearance, ongoing substance misuse and a matter of secreting a mobile phone. At the time this was against prison rules rather than a criminal offence; the current system is more robust, and possession of a mobile phone in prison is now a criminal offence. In open prisons such as Kirklevington Grange this would mean a return to closed conditions, as well as the possibility of further charges being brought. The IMR noted that on the 19th May 2008, the board made a recommendation for Aaron's return to closed conditions which was endorsed by a governor, but this was overruled by the Governing Governor, who wanted the prison to continue working with Aaron. The Board recommended closer monitoring of Aaron and that he should be permitted to work only during the prison day. All of the reported indiscretions were included in the report for the Parole Board hearing.

- The IMR also noted a call to the prison from a person claiming to be an ex-partner, alleging that Aaron was pestering her. The records did not identify the details of the caller. The procedure for all prisons is that any such callers are requested to put information in writing to the Governor.

- At an Interdepartmental Risk Management Meeting (IDRMM) on the 14th October 2008, it was recorded that Aaron had a new girlfriend, and the Prison Probation Officer had been told to discourage this. The next IDRMM noted mixed reports from Aaron's employer, and also identified a concern that some of the other chefs were involved in drug-taking, and that this was of concern given Aaron's background. The IDRMM minutes stated that it was not possible to drug test Aaron, due to his working late and returning to the prison late as result. The IMR noted that it was of concern that the minutes did not contain any more detailed information, or any follow up actions. Meetings were not always well attended. The IDRMM process was a new development at the time, and has changed significantly since 2008; currently, all risk assessment documentation is reviewed, and a Risk Assessment Board records the outcomes and any further actions required. A prisoner management tool has also now been implemented to monitor all reported indiscretions, even if unsubstantiated, to enable this to be monitored for any emerging patterns.

- The progress report summary prepared by the Lifer Manager on 20th April 2008 supported the release of Aaron. The report also stated that Aaron had been offered full time employment with his step-father, but that this was not viable due to the exclusion zone. The IMR concluded that, whilst recommendations made were based on the information provided, more details should have been made available.

- Aaron was released in December 2008, following the decision of the Parole Board.

- HMP Kirklevington encountered significant difficulties in compiling their IMR due to changes in offender management recording systems and gaps in information that had not migrated across.

- Procedures within HMP Kirklevington have undergone radical changes since 2008 when Aaron was released from custody, and significant improvements have already been made. Kirklevington Grange has had two visits from Her Majesty's Inspectorate of Prisons and Probation, and both of these have awarded the Offender Management systems in place the highest marks possible. The most recent visit was January 2015, where the current system was noted as the best offender management in the service.

13.6 <u>Review of information submitted by Parole Board</u>

- The Parole Board met at HMP Acklington for an oral hearing on 6th September 2006, to consider whether the detention of Aaron was still necessary for the protection of the public. The decision was made that Aaron was not considered satisfactory for release, but directed a move to open conditions. The Parole Board letter identified substance misuse as a risk factor, but later stated there was no evidence of any further substance misuse.

- The Parole Board met on 18th November 2008, and decided that it was appropriate to direct the release of Aaron on Life Licence, with a number of conditions attached. The letter from the Parole Board stated that "the only opinion expressed that Aaron's risk cannot be managed in the community was that of the Trainee Psychologist, in her report dated 18th July 2008" (HMPS clarified that this would have been a psychologist in training rather than a trainee from the university). She thought that Aaron needed "to do further work to address peer relationships, thinking and behaviour arising out of the behaviour which led to the adjudications". The Parole Board believed that these concerns had been dealt with adequately through the package put together by the Offender Manager.

13.7 Review of IMR prepared by Northumbria Probation Trust

- The IMR included a detailed and extensive history of involvement with Aaron between 2000, when he was transferred from Youth to Adult Services, and 2013, when he killed Jessie. During this period Aaron was seen regularly by Northumbria Probation Trust as part of life licence conditions, including risk assessments and lifer progress reports.

- The IMR noted the misgivings of the prison Trainee Psychologist (HMPS clarified that this would have been a psychologist in training rather than a trainee from the university), contained in a report written by her in July 2008. These related to his conduct at HMP Kirklevington, especially adjudications for drugs found in his cell, and possession of a mobile phone SIM card. She also questioned whether he had come to terms with the emotional impact on him of the index offence, and the death of his father. These concerns were acknowledged and shared by the Offender Manager, who had discussed this with her and who subsequently wrote a report in October 2008 for the Parole Hearing. The report detailed the concerns, and proposed that instead of Aaron's imprisonment continuing, he be released, with a detailed plan to carry out the necessary work in the community.

- The IMR includes two disclosure interviews, the first with Jessie and the second with her mother, with Aaron and the Offender Manager present. The records contain detail but not an exact account of what was disclosed, but states that full disclosure information was given, and that the victim had already shared the details with her family. The Offender Manager recalled the mother of the family being surprisingly forgiving, and saying something to the effect that everyone deserves a chance. Practice has subsequently changed in relation to Multi-Agency Public Protection Arrangements (MAPPA) disclosure. For cases managed at level 2, the Review Panel agrees what should be shared and by whom, and this agreement is recorded in the level 2 meeting minutes. The person or agency undertaking the disclosure will vary. Where police carry it out, those receiving the information sign a document to confirm that they have had disclosure, and that they understand it is confidential.

The subsequent MAPPA meeting will confirm that disclosure has taken place as agreed.

- The IMR identified omissions in risk management, insofar as the MAPPA meetings missed the fact that there were children living at the victim's home address, and that a Children and Families Social Care referral should have been made and that agency invited to MAPPA meetings in line with procedures. A Review Panel system for MAPPA level 2 meetings has subsequently been introduced, to achieve consistency in invitations to, and attendance by, all agencies.

- The Offender Manager also observed children in the house (Jessie's younger siblings) when he visited for the disclosure meeting, but did not make a referral to Children and Families Social Care.

- The IMR noted Offender Manager 2's repeated reliance on Aaron's self-report about his contact with his G.P., and did not contact the G.P. to seek verification of Aaron's accounts.

- The pre-release referral to MAPPA level 2 was made partly to verify reports of Aaron entering an exclusion zone during a period of temporary release (no evidence was found to support the report), and further, to ensure multi-agency involvement in decisions concerning risk management. The first level 2 meeting took place on 21/02/2008, and subsequent meetings confirmed the decisions around additional licence conditions. The fact that the meeting agreed in March 2009 to reduce the level of management to level 1 indicates the agencies' satisfaction that the case was being managed effectively at that stage. The MAPPA meetings pre-date the adoption of a Review Panel system in Northumbria, and were chaired, pre- and post-release, by a Team Manager.

- Upon release Aaron was allocated a named Police Officer from the Police Public Protection Unit, a Hostel Key Worker, and a Drugs Worker, in addition to his Offender Manager. The licence conditions included an exclusion zone, to keep him out of the vicinities of the victim's family and the co-accused and his family, and also conditions to engage with drug treatment and testing. It was arranged that the Drug Intervention Programme (DIP) team would carry out the testing, but the DIP team withdrew, believed due to funding issues. Aaron was therefore subject to drug testing only in approved premises, as are all residents, though not often, and not for long (23/01/09, 10/09/09, 21/09/09 and 04/02/10). All but one of these tests were negative, the exception being 10/09/09, the result of which was inconclusive. Where hostel staff have suspicions about drug use, more frequent testing is carried out; Aaron's behaviour at the time raised no such suspicions. After Aaron left approved premises, he was not drug tested.

- The IMR noted the number of home visits made to Aaron by his Offender Manager, though these do not usually include a check on all rooms.

These visits took place on 16/04/10, 21/04/10, 22/10/10, 12/08/11, 21/06/12, 15/03/13.

- In consultation with the Parole Board, the exclusion zone was altered in 2013, to allow Aaron to visit family members.

- The IMR noted a case-note entry made by the Offender Manager on 21st August 2013 which at the time did not raise concerns, but with hindsight might have been evidence of a different mental state: "Aaron attended, completed family tree genogram and discussed his interest in conspiracy theories around ancient Egypt and the North and South Pole fascinating discussion."

- The IMR noted that Aaron had 3 Offender Managers after being released from custody. Case transfers are supposed to be kept to a minimum, especially for life sentences or extended sentences. The review of these concluded that whilst the first transfer was managed well, the latter two were less carefully handled.

- A Serious Further Offence (SFO) Review was undertaken by the Director of Offender Management from Northumbria Probation Trust, in accordance with Ministry of Justice procedures, the purpose of which is to investigate the standards of risk assessment, risk management and offender management of a case. The review conducted into this case concluded that all three had been carried out to a sufficient standard. Lessons learned from the SFO review were largely relevant only to Northumbria Probation Trust's internal policy and practice. Areas of key learning were related to the omission to contact the G.P. and handling of case transfers.

13.8 The Serious Further Offence Review recognised the following areas of good practice:

- The first Offender Manager's careful work in preparing Aaron for release to Approved Premises and for his eventual move to independent living; and the Offender Manager remaining involved for two months after Aaron left the hostel, and then transferring the case only when all were satisfied that Aaron could manage in the community.
- The second Offender Manager's referral of Aaron to a CPN for a mental health assessment following concerns about his low mood and isolation.
- The third Offender Manager's positive approach in increasing the frequency of reporting on Aaron in order to build a relationship with him and thus understand his behaviour.
- The Team Manager's close oversight of the case in supervision, and detailed recording of his assessment of progress and actions needed.

13.9 <u>Review of IMR prepared by Northumbria Police</u>

- Northumbria Police IMR identified no relevant contact with Jessie and only 3 contacts with Aaron since his release from prison in 2008. He was

stopped on two occasions after failing to pay his Metro fare, and both he and Jessie were stopped during an operation to curb anti-social behaviour. No action was taken. Aaron was stopped on one occasion after a report of youths riding motorbikes on sand dunes, at which time he was issued with a fixed penalty, and on one occasion when he was driving his vehicle in company with another male, known to Northumbria Police. No further action was taken. The IMR concluded that all of these incidents were handled at the correct level with no escalation required to senior officers.

- No reports were made to Northumbria Police of any domestic abuse between Aaron and Jessie. Family members have also stated that they were not aware of any abuse between them.

- On release from prison, Aaron was managed under the Multi Agency Public Protection Arrangement (MAPPA). This is a statutory arrangement, which was developed to manage sexual and violent offenders. The arrangements enable the Responsible Authorities (RA), which consists of the Probation Service, Prison Service, and Police, to effectively manage the potential risk posed to the public.

13.10 Review of IMR prepared by Clinical Commissioning Group on behalf of NHS England (commissioners of G.P. Services)

- South Tyneside Clinical Commissioning Group's (CCG) IMR identified that both Jessie and Aaron were registered with separate G.P.s in the local area. Jessie was seen by her G.P. practice on 21 separate occasions between June 2009 and September 2013, 8 of which were related to pregnancy (3 miscarriages; July 2009, October 2009 and February 2013); and other consultations in relation to stress/depression, abdominal pain, drug dependency and general malaise. A referral was made to a Drug and Alcohol counsellor, medication prescribed, and a 'sick note' issued. The IMR found that there was evidence of detailed assessments of physical presentations; however Jessie's low Body Mass Index (BMI), poor diet, frequent health attendances, suspected Urinary Tract Infections (UTI) with resultant normal investigations, mental health issues, and her drug dependency, should have triggered concerns around her social circumstances. This highlights several missed opportunities for G.P.s to have considered the overall picture, rather than separate medical issues, and to have applied 'selective enquiry' regarding the possibility of domestic abuse.

- Jessie last attended her own G.P. Practice ten days before her death, when she presented requesting a 'sick note' relating to 'Tramadol misuse'. A 'sick note' was issued and, as she had not received any appointments from 'First Contact Clinical', contact was made with them to fast-track the referral. As they were unable to locate this, the original referral from June 2013 was re-faxed.

- On the day prior to her death, Jessie attended the G.P. Practice where Aaron was registered and spoke to a G.P. to express concerns about Aaron's strange behaviour (see page 25, 11.7). The G.P. made an appointment to see Aaron at 3:00pm the same day. It was agreed that Jessie would ring to speak to the G.P. in the event she could not get him to attend and the G.P would ring her if they didn't hear anything. It was identified as good practice that the G.P. at the practice had agreed to see Aaron 's girlfriend.

- The next record states "patient appointment cancelled" and that the G.P was unable to get through to speak to Aaron. The G.P sent a message to all staff to get Jessie's number if she called.

- A further record was made by the G.P. on the same day, stating that the Mental Health Crisis Team was contacted "just to get an opinion" to see if there was anything else that could be done, however this did not prove to be 'really helpful'. The Crisis Team said that it depended on the G.P.'s 'level of concern'. The Crisis Team suggested that the G.P. could 'phone the police; however, the G.P. felt that this was "far too heavy-handed". The G.P. explained that this was not a referral of Aaron, but rather that the G.P. wanted to 'talk it through'.

- The IMR identified a significant gap of 10 years and 7 months (05/06/96 to 09/01/07) in medical records available for Aaron, corresponding to the period of time that he was in custody. No contact was made with the G.P. by the Offender Manager, and therefore the G.P. was reliant on self-disclosure concerning Aaron's social, physical and mental wellbeing.

- Aaron was seen by his G.P. Practice on 8 separate occasions between November 2010 and June 2011, with stress/depression. During the initial consultation Aaron disclosed that he had been in prison from the age of 15 years to 27 years, serving a sentence for murder, that he had a "Probation Officer", and that he was not allowed to go to the area where his family lived. He also said that he had been depressed for decades, particularly during the last 2 years, since being released from prison. His sleep pattern was poor- only 2 hours per night since his release-; he slept during the day, and was experiencing nightmares- 'wakes in a fright thinking he is still in prison'. He also twice denied any illicit drug use during the initial consultation.

- Over this 7-month time period, he was provided with sickness certificates, prescribed anti-depressants, and referred 3 times (Nov 2010, Jan 2011 and June 2011) to the Primary Care Mental Health Team (PCMHT). He did not attend any appointments, and the G.P. was notified that he had been discharged after each episode, when attempts were made to make contact 'via letter at various intervals' following each referral.

- On 31/03/11, the G.P. Practice received a comprehensive letter and copy of an assessment conducted on Aaron on 22/03/11 by the Criminal

Justice Liaison Nurse, Northumberland Tyne and Wear NHS Foundation Trust (NTW), having been referred by his Offender Manager. Key concerns related to his being unable to adjust to his new environment due to his exclusion zone, his worries about being recalled to prison, and his pessimism about the realistic chances of gaining full-time employment. It was reported that he had formed a new relationship with his supportive girlfriend, and was positive about their future. However the report also stated that his poor mental health, his difficulty in adjusting to being on license for life, and his self-isolation, impacted on his relationship with his girlfriend. The assessment concluded that Aaron had mild to moderate depressive symptoms and, in the absence of suicide and self-harm, there was no current role for NTW but a recommendation to progress counselling with the PCMHT and for continuing review by his G.P..

- Following this assessment Aaron was reviewed by his G.P. a further 3 times, on a monthly basis, around his mental health issues. Medication was increased on 14/04/11. The G.P. used the Patient Health Questionnaire 9 (PHQ-9), which is a screening tool validated for use in Primary Care, and is designed to assess the patient's mood over the previous 2 weeks. On 18/05/11 it was recorded that sleep was a major issue, although there was some improvement, and his patient health questionnaire PHQ-9 score was recorded again as 22/27. This is graded as 'severe' depression.

- The G.P. Practice had no further direct contact with Aaron following his attendance on 23/06/11 and third and final referral to the PCMHT, with the exception of an out-of-hours contact on 15/05/13 with Northern Doctors Urgent Care, for a minor ear complaint.

- A G.P. emphasised the difficulties that face G.P.s in assimilating all the information for patients they may or may not see on a regular basis, and the resources available to deal with this.

13.11 Review of IMR prepared by South Tyneside NHS Foundation Trust (STNHSFT)

- The IMR identified no direct contact with Aaron, but Primary Care Mental Health Services had received three G.P. referrals for Aaron. On each of the three occasions when Aaron was referred to the South Tyneside NHS Foundation Trust, protocols were followed, with the Primary Care Mental Health Team communicating in writing to invite Aaron for planned intervention. Following non-attendance at the first appointment, the service followed up in writing, providing opportunity for a second appointment. On the second non-attendance, following protocol, the service discharged Aaron back into the care of his G.P. This process was repeated following the two subsequent referrals to, and non-attendances at, the Primary Care Mental Health Team.

- The IMR identified only two brief contacts with Jessie, through Obstetrics and Gynaecological Services, in July 2009 and in February 2013 via the Accident and Emergency Department. These related to two miscarriages, which occurred during the early stages of pregnancy, one at ten weeks and one at six. No domestic abuse risk indicators were identified at the Accident and Emergency admissions, and therefore routine or selective enquiry was not applied.

13.12 Review of IMR prepared by Northumberland, Tyne and Wear NHS Foundation Trust

- Northumberland, Tyne and Wear (NTW) NHS Foundation Trust had no involvement with Jessie, but had carried out three mental health assessments on Aaron. Two of these occasions were in 1996, when Aaron was a juvenile, and were therefore outside of the scope of this review, but provided helpful background. NTW were not active with Aaron prior to the time of homicide. Their last involvement was in 2011, following a referral to the Criminal Justice Liaison Nurse from the Offender Manager for a mental health assessment. This identified no risks to self or others that required further exploration/intervention other than what was already made known by the referrers; but it did identify that Aaron had mild to moderate depressive symptoms, which in the absence of suicide or self-harm could be managed by Primary Care Mental Health Services. This comprehensive assessment, and advice to the G.P. within the discharge summary to refer to counselling, was felt to have been appropriate.

13.13 Review of IMRs prepared by South Tyneside Council

Children and Families Services

- The IMR identified 23 historical contacts with Jessie's family between April 2009 and 2011. None of these related directly to Jessie, who would have been an adult at the time. The IMR identified that the initial assessment undertaken in 2011 did not take a whole-family approach, and that this was a missed opportunity to establish who was resident in or spending significant periods of time within the home, and any associated risks.

- South Tyneside Council's Children and Families Services was completely redesigned in 2013 in order to ensure a more timely and robust response to children in need and their families. Therefore any learning has already been applied.

Public Health

- The Public Health IMR initially identified that substance misuse provider services had had no contact with Jessie or Aaron; however, information emerged through the CCG IMR that a G.P. referral had in fact been made to First Contact Clinical (FCC) services for Jessie, in respect of

prescribed medication in June 2013. FCC had deemed this referral inappropriate, due to it relating to prescribed medication. As the referral was seen as inappropriate, it was not entered into the recording systems. This highlights a serious concern regarding the storage of referrals considered to require no further action.

- On the 4th September 2013 the G.P. Practice had to re-fax the original referral, as this had not been entered on recording systems, due to the referral having being assessed as inappropriate. The IMR identified this as a potential missed opportunity for Jessie to engage with services, and also for learning in terms of recording and systems for storing referrals.

- A substance misuse practitioner was tasked with contacting the G.P. to discuss the management of Jessie within a primary care setting. However, the practitioner cannot recall if this was done, and there is no record of any contact regarding this on the G.P. recording system, EMIS.

13.14 Review of IMR prepared by Jobcentre Plus

- The IMR completed on Jessie identified that she had been dealt with, on either a face-to-face basis or by telephone, by 27 different Jobcentre staff within the Department for Work and Pensions (DWP) between the period 14 January 2008 to September 2013. It is normal practice for a range of benefit centre staff to be involved in administering benefit entitlements. Interventions consisted of fortnightly reviews of jobsearch activity with a Jobsearch Review Officer. The last recorded jobsearch review was in March 2013. The IMR noted that from March 2013 until the time of her death, Jessie was in receipt of Employment Support Allowance. The initial primary reason recorded was miscarriage; however from June 2013, medical certificates submitted stated that Jessie was misusing tramadol hydrochloride, and had an opiate dependence. Jessie failed to attend an appointment to complete the required Work Capability Assessment, which would have included participating in an assessment undertaken by DWP's medical services provider, Atos Healthcare.

- The IMR completed on Aaron detailed DWP's involvement with him from December 2008 until the date of Jessie's death. During this period, Aaron was seen by 33 different officers for fortnightly reviews with a Jobsearch Review Officer. These interventions were often less than 5 minutes. The IMR noted a period from 20 November 2010 to 26 July 2011 during which Aaron claimed Employment Support Allowance (previously sickness benefit). There was one isolated period in May 2013 when Aaron was sanctioned and lost entitlement to Jobseeker's Allowance for four weeks, because he did not attend a review intervention with Jobcentre staff or provide sufficient evidence to prove that he was looking for work.

- Throughout his spells of unemployment, even when participating in the Work Programme, Aaron remained subject to regular interventions from

Jobcentre staff to test that he was available for and seeking work, and therefore eligible for receipt of Jobseekers Allowance.

- Aaron was last seen on 11 September for a Jobsearch review. The Jobsearch Review Officer who saw him on this occasion had seen him on a few of his recent attendances, and did not detect any change in his manner or behaviour in the weeks leading up to the homicide. Aaron was described as positive about his future and waiting to apply for his Construction Skills Certification Scheme (CSCS) card, which would enable him to work as a labourer on building sites.

13.15 Review of IMRs prepared by South Tyneside Homes

- Homefinder provides customers with a range of housing options, advice and services, including access to council housing, renting in the private sector, mutual exchange, supported/sheltered housing, home improvement schemes, adaptations that allow people to remain in their current home, and schemes that allow customers to move out of borough. It also provides housing options advice and assessment of entitlement to housing assistance for people who are homeless or threatened with homelessness.

- Homefinder had only minimal involvement with Aaron in relation to processing his homeless application after discharge from the Bail Hostel. Assistance was provided under 'The Housing and Resettlement Protocol (HARP), and the duty ended after Aaron's successful bid for a property. A referral was also made for floating tenancy support.

- South Tyneside Homes had no direct involvement with Jessie, although the IMR identified that she had submitted an online housing application on 3 September 2013 (this was not made active, as supporting identification had not been provided). Due to the volume of applications received, there is no requirement to follow up on incomplete online housing applications, or procedure in place to do so.

- South Tyneside Homes' involvement with Aaron was on a very superficial level, and relate to managing his initial housing application, undertaking Safer Estates checks, formalising the tenancy agreement, and monitoring the tenancy. The IMR evidenced records of three annual gas services having been carried out, which identified no concerns as to the condition of the property, and four customer care visits, the last three of which were ineffective. As there were no indications of any problems or issues with the tenant or property it was therefore considered that there was no urgency to access the property.

- No issues were reported or noise nuisance reports received in respect of the tenancy. The tenancy agreement was solely in the name of Aaron.

13.16 Review of IMR prepared by Changing Lives

- Changing Lives are a voluntary-sector organisation who had brief involvement with Aaron, following a referral received from Probation via Housing Options. Their role was to provide support around accessing benefits, to assist with a claim for a furniture pack, and to help with G.P. and dental registrations. Following an initial visit, a support worker was allocated and Aaron was accompanied to the Jobcentre and assisted with an application for a furniture pack. Aaron disengaged from the service within two months. The IMR identified some learning in terms of greater use of multi-agency meetings to ensure improved information-sharing and also more structured processes for moving a client on from services.

13.17 Review of IMR prepared by North East Ambulance Service

- Involvement of the North East Ambulance Service was solely as emergency responders at the time Jessie's body was discovered.

13.18 Review of IMR prepared by Impact Family Services

- Impact Family Services is a voluntary sector organisation which works with victims of domestic abuse. They had no direct contact with or knowledge of Jessie. After the homicide, Impact Family Services received third-party information relating to Jessie, but this was investigated by Police and found to be not substantiated, and was therefore of no significance to the review.

Section Fourteen: Key Issues

14.1 The Parole Board letter dated 13 September 2006 contained conflicting information, stating that substance misuse was an identified risk factor, but then stating that there was no further evidence of substance misuse. The Review Panel questioned the decision taken to release Aaron, in the knowledge of the expressed view of the Psychologist-in-training, that his risk could not be managed within the community.

14.2 Information-sharing arrangements were identified as ineffective, due to the absence of any procedure for prison healthcare medical records to transfer with Aaron to the community G.P.. NHS England state that prior to 2006 responsibility for medical services lay with HMPs; medical records were in paper format, with poor systems for filing and sharing information. This service is now commissioned by NHS England Health and Justice, with improved administration, a robustly performance-managed provider model and an electronic system (SystmOne) in all prisons, to improve communication between prisons and the community. NHS England will only share medical information if the prisoner consents to this, as many prisoners do not want their G.P. to know they have been in prison. As a consequence of this, the ability of G.P.s to make accurate and informed assessments can be severely impaired.

14.3 The reliance on self-reporting of Aaron in respect of his contact with and treatment by his G.P., and the omission of the Offender Manager to have any direct contact with the G.P. to ensure accurate information sharing and risk assessment is a cause of concern. Probation guidance exists in relation to circumstances in which a service user is involved with a G.P. or other treatment provider in connection with issues which could have a bearing on their risk to others, risk to themselves, or risk of reoffending, whereby regular contact with the treatment provider should be maintained by the Offender Manager.

14.4 Aaron concealed his substance misuse from all agencies with whom he was involved. Information contained within the Psychiatric Reports states that Aaron reported that he had used Subutex for 10 years (approximately 16mgs a day) and amphetamine (£10 daily) and cannabis for 5 years. Whilst some agencies had information in relation to his history of substance misuse and others did not, the extent of this was not fully understood by any agency. Therefore there was a lack of evidence of a focus on substance misuse interventions after his release, which was considered by the Review Panel to be a significant missed opportunity.

14.5 Joint agency safeguarding responsibilities were overlooked by both Northumbria Probation Trust and the MAPPA process, in relation to Jessie's siblings aged 15 and 12, and her nephew, aged 4 at the time. Whilst Aaron's previous offence did not relate to children, this still presented a missed opportunity for Children and Families Services to undertake a risk assessment in line with procedures. This would have facilitated opportunities

for further discussion with Jessie's family about their level of understanding of Aaron's previous offence.

14.6 The matter of selective, versus routine, enquiry in relation to domestic abuse, arose due to the number of presentations of Jessie to the G.P. and to Accident and Emergency, all of which presented missed opportunities to explore Jessie's social circumstances and any issues of possible domestic abuse.

14.7 To inform the recommendations of this DHR, NHS England carried out an audit across both Acute and Mental Health providers across Cumbria, Northumberland, and Tyne and Wear, to seek clarification of the use of 'Routine and Selective Enquiry' across the Health Providers. The findings of this were that within Acute Trusts, Routine Enquiry is embedded within Maternity services; Selective Enquiry is also used in all but one maternity service. Selective Enquiry is used across Emergency Departments; however, across other service areas, there is no consistency of application for Routine & Selective Enquiry.

14.8 The comprehensive and detailed assessment carried out by the Criminal Justice Liaison service on 22 March 2011, described Aaron as feeling low and anxious since release, as having difficulty in adjusting to being on license for life, and as spending time in isolating himself; and stated that this impacted on his relationship with his girlfriend. There was no evidence of any discussion between the Offender Manager and Aaron about the assessment, or of any follow-up with the G.P. or Primary Care Mental Health, which presented a significant missed opportunity to undertake a detailed risk assessment in collaboration with the G.P.

14.9 Primary Care Mental Health followed protocol in terms of discharging Aaron back to his G.P. after failed appointments and offering an opportunity for a second appointment in writing. The Review Panel however, had discussions about the pattern of missed appointments, and the absence of any documentation within G.P. records detailing discussion with Aaron regarding the reasons for non-engagement. There was no evidence within G.P. records of any attempt to contact Aaron, after he made no further appointment following the last G.P. review on 23 June 2011. This presented a missed opportunity to undertake an accurate risk assessment.

14.10 The G.P.'s recorded entries for the day prior to Jessie's death did not evidence consideration of Jessie's safety, given the concerns she had relayed about Aaron and the G.P.'s description of Jessie's emotional state- "emotional, worried and upset". There was no record of any contingency plan in the event of Aaron's refusal to attend the arranged appointment, such as the provision of contact details for the Mental Health Crisis Team. The G.P Police statement states that when Jessie called the surgery back to leave her number, this was not recorded; the explanation given by the G.P was that this related to data protection issues, and the fact that Jessie was not a patient at the practice. This would appear to contradict G.P. records which state that "a message was sent to all staff to get her number if she

rings". The Review Panel noted that it has not been possible to further explore this with the G.P. through interview, due to the G.P. no longer being in this country.

14.11 G.P. records state that the NTW Crisis Team had been contacted for advice but not to make a referral. NTW could find no record of this. The G.P. statement to Police does not include any details about a call to the NTW Crisis Team.

14.12 The Offender Manager case-note recordings relating to disclosure lacked exact detail, and therefore it was not possible to fully evidence the level of detail shared with the victim's family, in relation to weapons used and Aaron's exact role in the murder offence.

14.13 The DHR identified a number of gaps in agency records:

- South Tyneside Foundation Trust had no records relating to Jessie's second miscarriage in October 2009
- First Contact Clinical had no record of the G.P. referral in June 2009
- NTW had no record of the G.P. contact to the Mental Health Crisis Team
- HMP Kirklevington were unable to locate certain information due to system changes and migration issues

14.14 The licence conditions included an exclusion zone to keep Aaron out of the vicinity of the victim's family, and that of the co-accused and his family. The Review Panel however, considered the exclusion zone to be disproportionate, and felt that this had added to Aaron's isolation from his family and also significantly restricted his employment opportunities. It is unclear as to how often the exclusion zone was reviewed until it was significantly reduced six months before Jessie's death, which was four years after his release.

14.15 The Review Panel did not draw any conclusions, but did consider whether it was possible that there had been any minimisation by professionals of the risk posed by Aaron, due to the fact he had been a juvenile when he committed the first murder and sentenced to life imprisonment.

Section Fifteen: Lessons to be learnt

15.1 CCG on behalf of NHS England (commissioners of G.P. Services)

- Ineffective communication and information sharing was evident between the prison authorities, Northumbria Probation Trust and the G.P. Practice concerning Aaron's complex history to enable accurate risk assessments to be undertaken. There was a complete systems failure relating to medical information being transferred from the prison authorities to primary care services at the time of his release.

- Despite several triggers being evident, routine enquiry into domestic abuse was never considered or undertaken for Jessie by any professional within the G.P. Practice. Medical issues were seen in isolation and there was no consideration of the overall picture and the possibility of domestic abuse.

- There is no evidence that the safety of Aaron's girlfriend (Jessie) was given due consideration when she returned to an uncertain situation to inform Aaron she had consulted with his doctor and had made an appointment for him for later that day.

15.2 National Probation Service (NPS) and Northumbria Community Rehabilitation Company (CRC)

- With regard to Aaron's involvement with his G.P., Offender Manager 2 repeatedly relied on Aaron's self-report and did not contact the G.P. to seek verification of his accounts. This was the case when Aaron said he was no longer being prescribed antidepressant medication (February 2013). It is already Northumbria CRC policy and MAPPA guidance that where a service user is involved with a G.P. or other treatment provider in connection with issues which could have a bearing on their risk to others, risk to themselves, or risk of reoffending, regular contact with the treatment provider should be maintained by the Offender Manager. This was an omission on the part of one Offender Manager rather than a gap in policy or procedure.

- Guidance on case transfers, states that Offender Managers and team managers should review carefully any case transfers involving (especially) life sentences or extended sentences, to keep them to a minimum and ensure they are conducted with careful regard for effective risk management and with a view to minimising disruption to effective working relationships. The second and third transfers were less carefully handled although there is no evidence that this led to Aaron in any way disengaging from probation involvement.

- The shortcomings identified around the missing information about children in the home and the failure to invite Children and Families Social Care to the MAPPA meetings are all acknowledged. At that time MAPPA

meetings were chaired by community supervision team managers who had rarely received specific training in the role and had limited support in coordinating them. Changes to MAPPA adopted since then led to real improvements in practice, with administration centrally coordinated, training, support and auditing provided, and 'standing Review Panels' made up of agencies who have a duty to cooperate in attending meetings.

- The licence conditions included conditions to engage with drug treatment and testing; however, after the DIP team withdrew no alternative provision was identified, and Aaron was only subject to very limited drug testing in approved premises; and after Aaron left approved premises, he was not drug tested.

- The case recordings relating to the disclosure interviews with Jessie and her mother did not provide a detailed account of what information was shared about the previous murder offence. Neither was there anything signed to confirm that the disclosure had been received and understood.

15.3 Changing Lives

- The IMR identified gaps in working practices and recording of information as a result of staff not being properly inducted to the organisation.

- It was identified that recording systems did not contain the necessary alerts on potential high risk service users.

- There was an absence of control measures to ensure that policies and procedures are read, understood and maintained by all staff ensuring that information gathering, sharing and recording are followed correctly.

- A gap was identified in a facility to discuss new referrals in order to manage any identified risk.

15.4 HMP Kirklevington

- Risk assessment processes were not sufficiently robust at the time of Aaron's imprisonment at Kirklevington and as a result security breaches should have been analysed further to enable informed decisions to be made relating to management of risk.

- Inter Departmental Risk Management Meetings did not have the required representation from key agencies, records of meetings did not contain all the necessary information, and there was limited evidence of concerns being followed up.

- The IMR identified a number of gaps in records and missing information linked to the implementation of new IT systems and records not migrating across. Difficulties were also encountered in locating archived paper

records. This is clearly not conducive for the purpose of compiling historical reports.

- At the time of Aaron's imprisonment Offender Supervisors were required to undertake a plethora of other tasks and therefore only had a few hours per week to fulfil the role of addressing the risk factors presented by prisoners and providing interventions aimed at reducing offending.

15.5 South Tyneside Homes including Home Finder

- The absence of follow up procedures in relation to incomplete housing applications.

- Quality issues were identified to do with the recording of information in relation to contacts with housing applicants

- A gap was identified in procedures for follow up of ineffective tenancy support visits

- Communication and recording between agencies was made difficult due to incompatibility of IT systems, which hampered transfer of data. Internally agency records which were not always comprehensive. Additionally, archived data was not easily accessible.

- The IMR was unable to identify if Aaron had been subject to multi-agency meetings under 'The Housing and Resettlement Protocol' (HARP). These minutes are protected under data protection and were not available.

15.6 Impact Family Services

- The IMR identified the absence of staff guidance in respect of the management of third party information to assist in assessing significance and risk.

15.7 Jobcentre Plus

- The IMR identified a lack of continuity of customer care arising from number of advisors having contact with customers. From June 2015, Jobcentre plus is revising its Work Coach intervention delivery model. A claimant who makes a claim to Jobseekers Allowance, or engages with a Jobcentre by virtue of claiming Income Support or Employment Support Allowance, will receive on-going support from a dedicated Work Coach. This means that a claimant will see the same member of Jobcentre staff every time there is an active intervention between the claimant and the Jobcentre, even when the claimant attends the Jobcentre to complete a regular fortnightly jobsearch review (commonly known as "signing on"). This change will significantly enhance and improve the 1-2-1 relationship between Work Coach and claimant as well as the overall level of customer service provided by Jobcentre Plus.

15.8 South Tyneside Council - Public Health

- The IMR identified that potentially, additional support could have been given to Jessie regarding her Tramadol use at the first point of referral in June 2013. This could also have been a missed opportunity for the victim to engage with services.

- The recording processes should have been more effective confirming whether the G.P. was contacted by the substance misuse practitioner or not.

- Substance misuse services recording methods and information exchange between G.P. practice need to be revisited, clarified and embedded in practice.

- The IMR identified a gap in relation to wider training and support regarding prescribed medication and addiction which can be provided by commissioned substance misuse services to G.P.s.

15.9 South Tyneside NHS Foundation Trust

- The IMR identified that routine and selective enquiry is not clearly embedded in practice, particularly in the accident and emergency department.

- A gap in records was identified due to missing information relating to Jessie's attendance at accident and emergency in October 2009.

Section Sixteen: Conclusions

16.1 In reaching their conclusions the Review Panel has focused on the following questions:

- Have agencies involved in the DHR used the opportunity to review their contacts with Jessie and Aaron in line with the Terms of Reference (TOR) of the review and to openly identify and address the lessons learnt?
- Will the actions they take improve the safety of victims of Domestic Abuse in the Future?
- Was the death predictable?
- Was the death preventable?

16.2 The Review Panel commends the manner in which organisations have used their participation in the review not only to identify lessons and recommend actions arising from their contact with Jessie and Aaron but have taken the opportunity to embrace wider organisational learning.

16.3 After considering all of the information provided the Review Panel concluded that the death could not have been predicted. However, due to the absence of any documented robust risk assessment the Review Panel were unable to answer what support or consideration was given to Jessie's own safety by the G.P. on the day prior to her death. This is due to an absence of information in records and not being able to speak with the G.P. concerned due to them no longer being in the country. Without this the Review Panel felt it was not possible to reach a conclusion as to whether the death was preventable.

16.4 The Review Panel did not find evidence of any history of domestic abuse between Aaron and Jessie. It did however conclude that there were a number of indicators that should have triggered concerns and warranted exploration of her social circumstances, which meant opportunities had been missed to carry out a full risk assessment.

16.5 The Review Panel were unable to draw any firm conclusions in relation to the incomplete housing application, but hearsay suggested that this was a joint decision between Jessie and Aaron.

16.6 The Review Panel felt that due to the absence of any information sharing between Northumbria Probation Trust and the G.P. there had been a significant missed opportunity to carry out a detailed risk assessment of the couple's circumstances.

16.7 It has not been possible for the Review Panel to draw any conclusions in relation to the extent of Jessie's alleged Tramadol misuse due to gaps in information and conflicting information from family and friends. Similarly Jessie's alleged amphetamine misuse has only been reported by the perpetrator.

16.8 The Review Panel felt that the absence of any arrangements for prison healthcare medical records to transfer with Aaron to the community decreased opportunities for informed and accurate assessments. This was further compounded by the absence of any information sharing and communication between Northumbria Probation Trust and the G.P. which allowed Aaron to self-report on his medical treatment without any validation.

16.9 Aaron talked extremely positively about his partner to the agencies with which he engaged, Jessie was therefore seen as a positive and strength factor for Aaron. There was however a clear lack of any robust risk assessment in relation to any risk that Aaron presented to Jessie.

16.10 There were a number of missed opportunities for the application of a 'think family' approach. Whilst this would have required the consent of Aaron, family members could have played a supportive role in encouraging engagement with mental health services and informing assessments of how he was adjusting to life within the community. Aaron's family stated they had been engaged in the assessment and review process whilst he was in custody but that this had ceased since his release.

16.11 Whilst Children and Families Social Services had the opportunity to ask questions about significant people within the household, they never received any referrals notifying them that Aaron was spending significant periods of time in a house where children were present and that he had a previous conviction for murder. Whilst his previous did not relate to children, procedure is that an assessment should have been carried out, given that he was spending time and having overnight stays in a house where Jessie's younger siblings were present.

16.12 Substance misuse remained a hidden factor for Aaron whilst he was on life licence within the community. The Review Panel felt that given the Aaron's background of substance misuse, this should have had greater significance attached to it in terms of interventions within the community. It was notable that the licence conditions in the Parole Board report included regular drug testing, but only four were evidenced to have taken place. This was considered to be a significant missed opportunity.

16.13 It is evident that both NHS South Tyneside Foundation Trust (STFT) and NTW NHS acted according to protocol in following up missed appointments and referring back to G.P. The Review Panel were of the view that cases of known and pre-existing risk factors should warrant more proactive methods of engagement and follow-up by the respective agencies. Information contained in psychiatric assessments 'post-incident', state that Aaron had exaggerated his depression in order to avoid undertaking employment courses. In the case of Aaron however, the G.P. had only Aaron's self-report on which to assess the potential risk.

16.14 The Review Panel noted a number of omissions in the MAPPA process and also risk management and decision making processes during the period that Aaron was in HMP Kirklevington. Procedures within HMP Kirklevington and MAPPA have undergone radical changes since 2008 when Aaron was released from custody. There have also been national changes within the Ministry of Justice since 2008 with the creation of the National Offender Management Service (NOMS) which brought closer working practices between HMPS and the Probation Service.

16.15 The Review Panel explored the decision of the Parole Board to release Aaron in 2008. They concluded that this decision had been made in full knowledge of all the available information, including the three adjudications in respect of Aaron's indiscretions in custody and also the objections of the psychologist in training.

Section Seventeen: Questions raised by the Victims Family

17.1 Why Probation did not tell them of the full extent of Aaron's previous offence including weapons used and level of violence?

The DHR concluded that two disclosure meetings had taken place; one with the victim and the perpetrator, and the other with the perpetrator and the victim's mother. This issue was explored thoroughly in the IMR completed by Northumbria Probation Trust, including a review of the case file and also an interview with the Offender Manager. The Chair further examined this matter, requesting to see a copy of the contemporaneous case recording of the disclosure meetings, and conducting an interview with the perpetrator and his family. The case recording entry in relation to the disclosure interview with Jessie states that Aaron attended with Jessie and that it was evident from the content of the discussion that the "conviction had already been discussed, with both parties reciting the details of the murder." The case record relating to the disclosure with Jessie's family states "offence disclosure made by Aaron, was aware of this previously through Jessie." This was reinforced through accounts given by the Offender Manager and the perpetrator. The records however, did not provide an exact account of what detail was disclosed in relation to; weapons used and Aaron's exact role in the murder offence.

17.2 Why Social Services did not intervene following Jessie's booking with midwifery services, given Aaron's background?

Jessie had only ever had an initial 'meet and greet' booking with the community midwife at the G.P. surgery in June 2009, when Jessie was 7 weeks pregnant. This is only a preliminary 20 minute appointment, and is an opportunity for the midwife to issue the woman with her hand-held notes for completion prior to booking, and to give health information regarding diet, folic acid, vitamin D and antenatal screening. The formal booking was due to be booked for two weeks later, which is usually an hour-long appointment at which a risk assessment is completed and routine enquiry carried out. This is however reliant on disclosure from the individual. As Jessie miscarried less than 3 weeks later, when she was 10 weeks pregnant, the formal booking never took place. South Tyneside NHS Foundation Trust therefore never had any information relating to Aaron or his background that would trigger a referral to Children and Families Social Care.

17.3 Why Social Services allowed someone with Aaron's background to be allowed to stay overnight or spend time in a house where children were present?

The DHR found that Children and Families Social Care had never received any referrals relating to Aaron spending time and having overnight stays in a house where Jessie's younger siblings were present. Northumbria Probation Trust IMR identified that a referral should have been made in line with procedure and

that this was an omission of the MAPPA process and also of the Offender Manager.

17.4 Why the G.P. did not do more when Jessie went into the surgery the day prior to her death?

The DHR was unable to fully answer this question due to the respective G.P. no longer being in the country. The DHR concluded however that there was an absence of any documented robust risk assessment to evidence that consideration was given to Jessie's own safety.

Section Eighteen: Recommendations

18.1 National Recommendations arising from the review;

- The Parole Board to consider including a mandatory requirement for all high risk prisoners subject to life licence conditions to have to register with a G.P. and give their consent to release prison health care medical records upon transfer into the community.

18.2 Individual agency recommendations arising from IMRs

CCG on behalf of NHS England (commissioners of G.P. Services)

- A review should be undertaken to ensure there is a consistent, robust approach in place for the transfer of medical information from the prison authorities to primary care services when an individual is released from custody.

- When it is known that there are other agencies involved, G.P.s should proactively communicate and work with them to gather and share relevant information to ensure an accurate risk assessment can be made around any complex presentations, including a history of violence, possible ongoing drug misuse, mental health issues and intimate relationships.

- G.P.s should ensure there are up to date domestic abuse policies and procedures in place within their organisation, and crucially that all staff are fully conversant with, and have the knowledge and skills to adhere to them.

- Lessons learnt from the DHR will be shared with all General Practices within South Tyneside.

NHS England Cumbria and the North East

- To implement steps to share learning from this review locally, regionally at the Independent investigation meeting who will share nationally the themes and trends.

- To implement steps to share learning from this review with the commissioners of Health & Justice to seek a solution to the sharing of medical records on prisoners release.

- To take the findings of the Routine and Selective Enquiry audit to the regional safeguarding forum to determine next steps; this should include Primary Care Services.

Northumbria Community Rehabilitation Company (NCRC)

- To undertake an audit to evidence that Offender Managers are routinely liaising with G.P.s and treatment providers in connection with issues which could have a bearing on people's risk to others, to themselves, or their risk of reoffending, in line with NCRC Policy and Guidance.

- To ensure relevance, proportionality and compliance of license conditions through regular review.

- To implement measures to ensure that transfers of Offender Managers are handled in line with best practice and Northumbria CRC policy and guidance.

National Probation Service (NSP)

Whilst NPS were not part of the DHR Review Panel (reference paragraph 9.3 page 13) they were consulted at the end of the review process and the following recommendations were agreed:

- To ensure Offender Managers routinely liaise with G.P.s, treatment providers, or other relevant health professionals to address physical, emotional and mental health issues where assessments indicate they are linked with the risk of re-offending or of serious harm.

- Ensure compliance with the current 'Probation Instruction regarding Case Transfers' (07/2014).

- To ensure relevance, proportionality and compliance of license conditions through regular review.

- To ensure consistency of practice amongst NPS and partner agencies in ensuring that those receiving disclosure information sign to confirm they have received it.

HMP Kirklevington

- To ensure continued learning and development surrounding risk assessment processes through continual review.

- To ensure a wide ranging membership at Inter Departmental Risk Management Meetings.

- To monitor the effectiveness of the combined Offender Supervisor/Senior Officer groups.

- To implement any future recommendations with regard to Release on Temporary Licence as per prison service instructions

South Tyneside Council - Public Health

- Public Health as Commissioners to ensure that all substance misuse services are underpinned by robust contract monitoring arrangements.

- Public Health to undertake an analysis of impact of the new First Contact Clinical referral criteria and referral pathway to monitor effectiveness of implementation.

South Tyneside NHS Foundation Trust

- To ensure level 3 targeted training to Accident and Emergency, clinical and staff is provided on routine and selective enquiry.

- To undertake an analysis of numbers of STFT A&E staff who have completed routine and selective enquiry training.

- To undertake an educational impact audit to evidence impact on practice following routine and selective enquiry training.

South Tyneside Homes including Homefinder

- To review what further action can be taken in circumstances when tenants do not respond to attempts to carry out Tenancy Support Visits. (These are carried out every two years as a minimum, and more often should individual circumstances dictate).

- To consider the feasibility of contacting all applicants who have submitted an incomplete Housing Register Application.

- To implement quality control measures for contact recording.

- To improve information and data sharing.

Jobcentre Plus

- To monitor and review implementation of the revised Work Coach intervention delivery model to ensure improved standards of customer care and continuity.

Changing Lives

- To ensure all staff and managers receive the organisation's new induction programme, or re-sit the new induction programme as a refresher course.

- To ensure all external and referral sources are informed of potential disengagement of support and they should automatically be informed during each stage of support, should these needs change at any time.

- To undertake an audit to ensure alerts are placed on all high risk service users.

- To ensure all staff have read and understand policies and procedures.

- To monitor implementation of weekly risk management meetings.

Impact Family Services

- To update in-house policies/procedures to include guidance for staff on the management of third party information and informing the Police in relation to criminal proceedings.

Chair’s recommendations

- Primary Care Mental Health services should review current procedures and methods of engagement with service users who are “harder to reach” to promote increased take-up of interventions.

- Northumberland, Tyne and Wear NHS Foundation Trust review systems and processes for providing advice and guidance to key stakeholders.

- National Probation Service and Northumbria Community Rehabilitation Company should ensure that all practitioners have attended Safeguarding Training.

Postscript

Actions to be taken after presentation of the Overview Report to the Community Safety Partnership;

On receiving the Overview Report and supporting documents, the CSP should:

- Agree the content of the Overview Report for publication, ensuring that it is fully anonymised apart from including the names of the Review Panel Chair and members;

- Make arrangements to provide feedback and debriefing to staff, family members and the media as appropriate;

- Sign off the Overview Report and supporting documents;

- Provide a copy of the Overview Report and supporting documents to the Home Office
- Quality Assurance Group. This should be via email to DHRENQUIRIES@ homeoffice.gsi.gov.uk;

The document should not be published until clearance has been received from the Home Office Quality Assurance Group.

On receiving clearance from the Home Office Quality Assurance Group, the CSP should:

- Provide a copy of the Overview Report and supporting documents to the senior manager of each participating agency;

- Provide an electronic copy of the Overview Report on the local CSP web page;

- Monitor the implementation of the specific, measurable, achievable, realistic and timely (SMART) Action Plan;

- Formally conclude the review when the Action Plan has been implemented and include an audit process.

Appendix A
Glossary of Terms

AAFDA	Advocacy after Fatal Domestic Abuse
BMI	Body Mass Index
CCG	Clinical Commissioning Group
CPN	Community Psychiatric Nurse
CSCS	Construction Skills Certification Scheme
DHR	Domestic Homicide Review
DIP	Drug Intervention Programme
DWP	Department for Work and Pensions
FCC	First Contact Clinical Services
HARP	Housing and Resettlement Protocol
IMR	Individual Management Review
MAPPA	Multi Agency Public Protection Arrangement
MARAC	Multi Agency Risk Assessment Conference
NCRC	Northumbria Community Rehabilitation Company
NOMS	National Offender Management Service
NPS	National Probation Service
NTW	Northumberland, Tyne and Wear NHS Foundation Trust
OCD	Obsessive Compulsive Disorder
PCMHT	Primary Care Mental Health Team
PHQ	Patient Health Questionnaire
RA	Responsible Authority
SFO	Serious Further Offence
STFT	South Tyneside Foundation Trust
TOR	Terms of Reference
TWFRS	Tyne and Wear Fire and Rescue
UTI	Urinary Tract Infection