Appendix C

Safer South Tyneside

Domestic Homicide Review

EXECUTIVE SUMMARY OF THE OVERVIEW REPORT

Into the death of Jessie

DHR Case Reference 001

Anonymised for publication and dissemination

Report Author: Jill Holbert MA

Date: 19 October 2015

Appendix C

CONTENTS

Appendix C

Section One: Introduction

This Domestic Homicide Review (DHR) examines the circumstances surrounding the death of Jessie.

1.1 At the time of her death, Jessie was living at the home she shared with her partner, Aaron, in the South Tyneside area. There were no other residents living at the address. Jessie was aged 24 years and Aaron was aged 32 years.

1.2 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.

1.3 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.

1.4 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.

1.5 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.

1.6 On the same evening 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.". 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.

1.7 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.

1.8 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.

1.9 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.

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

1.11 Three independent psychiatric assessments were carried out on Aaron for the criminal trial. Each of these made a diagnosis of the symptoms Aaron was presenting with at the time of killing his partner:

- Psychotic symptoms
- Paranoid Schizophrenia
- Acute and transient psychotic disorder

1.12 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'.

BACKGROUND:

1.13 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.

1.14 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.

Appendix C

1.15 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.

Appendix C

Section Two: The Review Process

2.1 The Review was commissioned by the Community Safety Partnership under Section 9 of the Domestic Violence, Crime and Victims Act (2004).

2.2 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 Domestic Violence Crime and Victims Act 2004.

2.3 The Chair of the Community Safety Partnership 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 Review would be taking place.

2.4 The Community Safety Partnership identified an Independent Chair of the panel and overview report author.

2.5 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.

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

2.7 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.

2.8 The first DHR panel took place on the 29th November 2013, to agree the Terms of Reference for the review, and decide which agencies were to undertake Individual Management Reviews (IMRs).

2.9 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.

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

Appendix C

Section Three: Contributors to the Review

3.1 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.

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

3.3 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).

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

3.5 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.

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

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

3.8 Family members of both the victim and perpetrator contributed to the review, as well as the perpetrator and some friends of the victim. All provided information, and some asked questions which the Panel included within their deliberations. The family members who engaged with the DHR were consulted by the Independent Chair during the course of the review and preparation of the Overview Report which has been shared with them.

3.9 Some of the information from family members and friends was conflicting. The panel made no judgements in respect of information from these sources.

Appendix C

3.10 Information provided by family and friends helped to gain a clearer picture of the relationship between Aaron and Jessie. It also provided valuable insight into Jessie as a person.

Section Four: Terms of Reference

4.1 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.

Appendix C

- 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 Five: Agencies Involvement

5.1 Individual Management Reports were completed by the following agencies:

- South Tyneside Clinical Commissioning Group (CCG) on behalf of GP 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

5.2 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.

5.3 North East Ambulance Service was involved solely as emergency responders at the time Jessie's body was discovered.

5.4 Impact Family Services had no involvement with the victim or information that was relevant to the homicide.

5.5 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.

5.6 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.

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

5.8 South Tyneside Homes including Homefinder's contacts with Aaron, related only to housing applications and tenancy checks were not thought to be of any relevance to the homicide. Similarly this was the case with Changing lives whose only involvement with Aaron had been very limited in providing tenancy support at the time of him acquiring his own tenancy.

5.9 South Tyneside Homes IMR had a record of Jessie starting a housing application ten days prior to her death, however this was never completed. The review could find only hearsay as to the rationale for this.

5.10 Newcastle City Council - Wellbeing, Care and Learning had extensive involvement with Aaron, from the age of 7 years up to his being sentenced and imprisoned for murder at age 16. None of these were of any direct relevance to the homicide.

5.11 South Tyneside Council, Children and Families Social Care had contacts in relation to Jessie's siblings but none considered of any relevance to the homicide.

5.12 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.

5.13 HMP Kirklevington Grange had extensive and significant involvement with Aaron between January 2007 when he was first transferred there and December 2008 when he was released. The IMR detailed escorted, resettlement and community visits, intelligence reports, work placements, adjudications, risk assessments, inter-departmental meetings and reports prepared on Aaron as a life sentenced prisoner.

5.14 Northumbria Probation Trust had extensive and significant involvement with Aaron from 2000 when he was first transferred from youth to adult services. The contacts detailed, MAPPA panel meetings, release on temporary licence, lifer progress reports, home visits, supervision appointments, interventions, work placements, disclosure meetings and transfers between offender managers. The IMR noted that he had reported as feeling depressed and having low mood on occasions but had stated that he was seeing his GP and receiving medication in relation to this. He was also referred for a mental health assessment. The chronology detailed 35 direct contacts with Aaron between January 2009 and the death of Jessie.

5.15 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, in 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 Drug and Alcohol counsellor and medication prescribed and sick note issued. 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.

5.16 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.

5.17 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.

5.18 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'.

5.19 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 relating to the period of time he was in custody. Aaron was seen by GP Practice on 8 separate occasions between November 2010 and June 2011. 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'. Over this 7 month time period he was provided with sickness certificates, prescribed anti-depressants, and was referred 3 times to the Primary Care Mental Health Team (PCMHT), but did not attend any appointments. The GP Practice had no further direct contact with Aaron following his attendance in June 2011.

5.20 South Tyneside NHS Foundation Trust (STNHSFT)'s chronology recorded Jessie as having attended chronology had records of Jessie attending Accident and Emergency on two occasions in relation to miscarriages. The IMR prepared by CCG on behalf of NHS England (commissioners of GP Services) identified two other attendances through notifications received by the GP from STNHSFT. One related to a further miscarriage and the other to abdominal pain. Jessie's last presentation at Accident and Emergency was approximately six months prior to her death and was in relation to abdominal pain, three weeks after her last miscarriage. No other concerns were identified.

5.21 Northumberland, Tyne and Wear NHS Foundation Trust (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 therefore outside of the scope of this review. NTW's 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 did identify he had mild to moderate depressive symptoms that in the absence of suicide or self-harm could be managed by Primary Care Mental Health Services.

5.22 The Public Health IMR initially identified that substance misuse provider services had had no contact with Jessie or Aaron. Information however, emerged through the CCG IMR that a GP 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. On the 4th September 2013 the GP Practice had to re-fax the original referral as this had not been entered on recording systems due to it being assessed as inappropriate.

5.23 Jobcentre Plus had contacts recorded in relation to both Jessie and Aaron. The appointments were routine and related to job search activity and working age benefits claims. The last recorded research review was in March 2013. The IMR noted that from March 2013 up 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.

5.24 Between December 2008 and September 2013 Aaron attended the Job Centre for fortnightly interviews with a Job search Adviser. He was last seen two days prior to the discovery of Jessie's body. The Jobsearch Adviser which 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. 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.

Appendix C

Section Six: Key Issues

6.1 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.

6.2 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.

6.3 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.

6.4 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.

6.5 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.

6.6 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.

6.7 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.

6.8 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.

6.9 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.

6.10 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.

6.11 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.

6.12 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.

6.13 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

6.14 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.

6.15 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.

Appendix C

Section Seven: Lessons to be learnt

7.1 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.

7.2 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.

7.3 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.

7.4 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.

7.5 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.

7.6 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.

7.7 Jobcentre Plus

6 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.

7.8 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.

7.9 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 Eight: Conclusions

8.1 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?

8.2 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.

8.3 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.

8.4 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.

8.5 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.

8.6 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.

8.7 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.

8.8 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.

8.9 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.

8.10 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.

8.11 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.

8.12 The matter of 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.

8.13 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.

8.14 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.

8.15 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 Nine: Questions raised by the Victims Family

9.1 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 relating 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.

9.2 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.

9.3 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.

9.4 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 Ten: Recommendations

10.1 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.

10.2 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 FCC 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.