West Cumbria Community Safety Partnership

Domestic Homicide Review in relation to Gerald

Date of homicide June 2020

Executive Summary

Independent Chair and Author: Stuart Douglass

Report completed August 2022

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1. THE REVIEW PROCESS

1.1 This summary outlines the process and key findings and learning undertaken by the West Cumbria Community Safety Partnership Domestic Homicide Review (DHR) Panel in reviewing the homicide of Gerald, a resident of Cumbria.

1.2 This review has been anonymised in accordance with the statutory guidance[1]. The specific date of the homicide has been removed. Only the chair and review panel members are named.

1.3 To protect the identity of the victim and the perpetrator and key contributors to the review, the following pseudonyms have been used:

Pseudonym	Relationship to subject	Ethnicity	Age at time of fatal incident
Gerald	Victim	White British	39 years
Mark	Perpetrator/brother of victim	White British	37 years
Sarah	Victims partner		
Paul	Friend of victim		

1.4 In July 2020 police were called to Gerald's home where he had been found murdered. Following investigation Gerald's brother Mark was arrested and charged with murder. Criminal proceedings concluded in December 2021. The prosecution accepted Mark's plea of guilty to Manslaughter on the ground that his mental state at the time of the killing was such that his responsibility for what otherwise would have been murder was diminished. Mark was sentenced to 21 years imprisonment.

1.5 The referral for consideration of a DHR to West Cumbria Community Safety Partnership was made on 29th June 2020 by Cumbria Constabulary.

[1] Statutory guidance for the conduct of Domestic Homicide Reviews, published December 2016, Home Office.

1.6 The referral was formally scoped in line with Home Office statutory guidance on 29th July 2020 with a range of key agencies and organisations who may have had previous contact with the victim/s and perpetrator.

1.7 The Community Safety Partnership notified the Home Office of their intention to undertake a Domestic Homicide Review on 4th August 2020.

1.8 All of the 11 agencies scoped confirmed contact with the victim/s and perpetrator and were asked to secure files.

1.9 The review was submitted to West Cumbria Community Safety Partnership in August 2022 and approved for submission to the Home Office at its Board meeting on the 13th September 2022. The Home Office indicated approval to publish In October 2023.

2. CONTRIBUTORS TO THE REVIEW

Sarah (partner of Gerald)	interview
Paul (close friend of Gerald)	interview
Cumbria Constabulary	Information report/investigation statements
Her Majesty's Prison and Probation Service	Information report
Cumbria County Council	Information reports/specialist safeguarding advice
Department for Work and Pensions	Information report
Allerdale Borough Council	Information report
Riverside Housing	Information report
Dr Stephen Barlow – Consultant Forensic Psychiatrist	Information reports
Dr Mark A. Turner – Consultant Forensic Psychiatrist	Information report
Human Kind	Briefing session to panel on New Psychoactive Substances

3. THE REVIEW PANEL MEMBERS

3.1 Members of the Panel were as follows.

Cumbria Constabulary	Detective Inspector Suzanne Redikin Detective Constable Sarah Edgar DHR/SPR Spoc
Cumbria County Council	Sarah Joyce, Service Manager Safeguarding Adults

North West Ambulance Service	Sharon McQueen, Safeguarding Practitioner (Cumbria/Lancashire area)
Independent Chair/Author	Stuart Douglass
Her Majesty's Prison and Probation Service	Emily Kirkbride, Deputy Head of Probation Delivery Unit - Cumbria
Clinical Commissioning Group	Molly Larkin, Safeguarding Designate Nurse, Adults and Children Looked After, Mental Capacity Act Designate and Court Protection.
Eden District Council	Clare Stratford – DHR Coordinator Cumbria
Independent Observer	Shona Priddey – (shadowing the chair)
North Cumbria Integrated Care NHS Foundation Trust	Sam Finn - Safeguarding Specialist Practitioner (Social Worker)
Human Kind	Linzi Butterworth, West Cumbria Team Leader
Allerdale District Council	Holly Cosgrove, Housing Options Manager
Cumbria Northumberland Tyne and Wear NHS Foundation Trust (CNTW)	Sheona Duffy, Acting Team Manager Safeguarding and Public Protection.

3.2 The panel met on 5 occasions. Panel members had no line management responsibility for any staff who may have contact with Gerald or Mark and the chair was satisfied that the panel members were independent.

3.3 The Review Panel would like to express its sympathy to the family and friends of Gerald for their tragic loss.

4. AUTHOR OF THE OVERVIEW REPORT

4.1 Stuart Douglass was appointed as chair and author. Stuart is an independent practitioner with over 30 years' experience in safer communities and safeguarding policy and reviews. Stuart completed Home Office approved DHR chair training in 2016. Stuart has not been previously employed by any agency in Cumbria.

5. TERMS OF REFERENCE FOR THE REVIEW

5.1 Terms of Reference were agreed at the Panel meeting on 1st March 2022 and contained general and agency specific key lines of enquiry and are attached as appendix 1.

5.2 The review panel considered chronologies of agency contact with the subjects covering the 5 years prior to the homicide and detailed reports covering the 12-month period preceding the homicide. The rationale was that scoping evidence indicated that Mark's mental health deteriorated rapidly in the months prior to the homicide.

6. SUMMARY CHRONOLOGY

6.1 The DHR identified that Gerald had no contact with any agencies scoped or engaged in this review time frame other than health services in respect of his sight disability and other health related issues. There were no issues of note regarding any interaction with Gerald and he was described by health staff as presenting as positive and friendly.

6.2 **September 2019**: Gerald is admitted to hospital with a transient ischaemic attack[2] .

6.3 **December 2019**: Mark contacts his local Council to request backdating of his Council Tax reduction stating that he has been late in applying due to "mental health issues".

6.4 **January 2020**: Mark contacts his mother by social media messaging and refers to events she cannot understand. Similar messages continue sporadically in the months prior to the homicide and include various accusations involving family members, neighbours, and wider community.

6.5 **February 2020**: Mark attends his GP practice to see a nurse practitioner with facial swelling and headaches. Medical notes consider cluster headaches, and he is prescribed medication.

6.6 **March 2020**: On 20th March the Prime Minister announces a UK-wide partial lockdown[3].

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[2] A transient ischaemic attack (TIA) or "mini stroke" is caused by a temporary disruption in the blood supply to part of the brain. The disruption in blood supply results in a lack of oxygen to the brain. This can cause sudden symptoms similar to a stroke, such as speech and visual disturbance, and numbness or weakness in the face, arms and legs. But a TIA does not last as long as a stroke. The effects last a few minutes to a few hours and fully resolve within 24 hours. Source https://www.nhs.uk/conditions/transient-ischaemic-attack-tia/

[3] This was followed 3 days later by the introduction of The Health Protection (Coronavirus, Restrictions) (England) Regulations 2020 (SI 2020/350)

6.6 **May 2020**: On the 18th, Mark contacted the Primary Care Centre (service that provided the town's GP Practice on the day appointments) via telephone and spoke to a GP to request a sick note. During the telephone contact Mark spoke of an alleged traumatic childhood event, advising that when he was seven, he was jailed because he attacked another child. Mark stated, "they died at first but then they got put on life support". Mark advised that his parents disengaged from psychiatric services so that he wouldn't be taken into care. The GP documented at the time '*no documentation of any of this; I'm sure if it is the case the GP will remember something as unusual*'. Mark advised that people who had been involved in the incident, came back to the area and everyone found out and he lost his friends and had to give up his job at Sellafield.

6.7 The treatment plan records short term medication and a referral to First Step[4] and the GP sent a task to Solway Health Services to request a sick note be completed (as they are unable to issue from the Primary Care Centre). Mark's symptoms were recorded as including feelings of intermittent thoughts of suicide, intrusive thoughts, poor sleep. Mark also advised that he is angry, outburst of temper wanting to harm himself and others, so he has isolated himself for two years and doesn't talk to his parents. The record showed no evidence of drug or alcohol misuse or an electronic warning flag for concerns about violent behaviour or domestic abuse.

6.8 **May 2020**: Four days later a different GP from Mark's registered practice follows up with a telephone consultation to Mark to discuss the sick note. It is recorded that the First Step letter had been received regarding the patient's failure to contact them. "Patient reported mood was better and no further suicidal ideas". He requested a sick note for 2 weeks which was posted. Reminded that he had 7 days to contact First Step re counselling to keep the referral active".

6.9 **May 2020**: Mark messages his mother with further conversations that she cannot understand, and she suggests he needs help. His response to the suggestion is abusive.

[4] First Step is part of Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust and provides free, talking therapies to adults (18+) in North Cumbria. First Step can help with a range of common mental health problems including mild to moderate depression, anxiety disorders (such as chronic worry, panic attacks, health anxiety and obsessions), mild bulimia, anger, or sleep problems).

6.10 **May 2020**: on the 30th the Government announce a relaxing of lockdown restrictions for people who have been "shielding" in their homes with those who live alone able to meet one other person outside.

6.11 **June 2020**: GP records note that First Step have advised the GP that Mark had failed to contact them within the allotted time. Five days later the GP tries to telephone Mark to discuss mood and failure to engage with First Step and records, “no answer and message left for patient to ring the surgery”.

6.12 Early **June 2020**: Close friends visit Gerald to talk to him in his garden (due to Covid restrictions). He is described as “upbeat”, and they will socialise again when restrictions lift

6.14 **June 2020** (approximately 5 days before the homicide is discovered): Gerald’s father goes to Gerald’s house to do some painting and gardening and in his account to the police described Gerald as, “making plans for the future and happy go lucky”.

6.15 **June 2020** (3 days before the homicide is discovered): a friend and former employer of Mark’s (who hasn’t had any contact with him for 5 years) is messaged by Mark with what he describes as bizarre messages.

6.16 **June 2020** (3 days before the homicide is discovered): Gerald and Paul message each other about football.

6.17 **June 2020** (2 or 3 days before the homicide is discovered): Mark’s mother visits him at his house. During the visit he becomes agitated, and she leaves considering, “one of his moods was coming on” and later described to police, “when I look back, he would increasingly flip from aggression to normality”.

6.18 **June 2020** (approximately 2/3 days before the homicide is discovered): Sarah visits Gerald to hand food and a gift of cakes. She leaves them behind the gate, and they talk socially distanced.

6.19 **June 2020** (2 days prior to the homicide being discovered): Mark contacts a cousin (they rarely have contact) via social media. The cousin described Mark as sounding either “*drunk or on drugs, possibly both*”. The conversation is described as “*not making sense. He was*

saying things and not elaborating on them". The cousin describes Mark making bizarre allegations that made "no sense". The call ends with Mark saying, "*Don't worry I'm gonna go up there tonight and kill him*".

6.21 Two days later Gerald's mother discovers Gerald deceased at his home.

7. KEY ISSUES ARISING FROM THE REVIEW

7.1 Gerald and Mark had been close throughout their lives, though Gerald had indicated that the contact had diminished slightly in recent years. From March 2020 Gerald was self-isolating due to COVID and his health vulnerabilities.

7.2 There was no evidence of any previous conflict between the two brothers and to the contrary numerous accounts evidenced that Mark had "looked out" for his brother both when growing up or when they were together in adult life.

7.3 Historical police and probation records demonstrate that Mark had a propensity for violent behaviour, having had previous police contact on 3 occasions between the age of 21 and 25 years, resulting in 2 convictions related to violence and domestic abuse offences. These contacts were prior to 2008 and Mark does not come to police attention again until Gerald's homicide 12 years later.

7.4 Mark had worked at a local power plant for a subcontractor though after that job ended, he only worked sporadically after that time.

7.5 Despite having health difficulties, being partially sighted and blind, and having a stroke in 2019, Gerald overcame these. He had worked full time since leaving school, bought his own home and led a full life socialising, travelling and regularly visiting the gym.

7.6 Gerald had been in a relationship with Sarah for almost three years. She spoke warmly of his thoughtfulness, kindness, and sense of humour. Sarah did not know Mark. She indicated that Gerald did not express any concerns about his brother nor exhibit any reason to be fearful or threatened by him or anyone other person in the period prior to the homicide.

7.7 There is evidence that Mark's drug use transitioned from cannabis use to smoking of "plant food" or "spice", an illegal synthetic cannabinoid.

7.8 In May 2020 Mark telephoned his GP to request a sick note but discloses that he had almost killed another child when he was a child and claimed he was imprisoned for it. He reports he has locked himself away for the last 2 years as he is suicidal, aggressive and wishes to harm others. The GP prescribes mild sedatives and refers Mark to a talking therapy service which he does not access. The GP checks records and can find no evidence of Mark's story. The GP is unaware from records that Mark is the carer of his child. A follow up call indicates he is improving but a subsequent contact is not responded to or followed up. Mark is not seen face to face by any medical practitioner in these contacts.

7.9 During the period December 2019 to June 2020, post homicide accounts from family and friends reviewed by Forensic Psychiatrists indicate Mark was paranoid and delusional[5] in certain aspects regarding his family, brother and wider community.

8. CONCLUSIONS

8.1 This report describes and analyses the events which led up to the fatal incident and the panel were able to establish an understanding of agency involvement with Gerald and Mark in the 12 months prior to the homicide. (Terms of reference - key lines of enquiry 1 and 2)

8.2 Gerald had physical health needs associated with his disability (and related conditions) and the review evidence indicated that health services in relation to this were responsive and accessible. (Terms of reference - key line of enquiry 3)

8.3 The review also evidenced that services were responsive and accessible to Mark, and he spoke directly to his local GP when he contacted them by telephone in May 2020. (Terms of reference – key line of enquiry 4)

8.4 There was no evidence that service responses to Gerald were affected by the COVID 19 Pandemic though Mark (when he contacted his GP asking for a sick note), was dealt with by two telephone consultations and a third (unsuccessful) telephone follow up, rather than be invited in to see the GP. The GP surgery were limiting face to face contact with patients at

[5] A delusion is where a person has an unshakeable belief in something untrue. https://www.nhs.uk/mental-health/conditions/psychosis/symptoms/

that time in line with national guidance, though the review understands that exception to this could be made if a GP considered this necessary. (Terms of reference – key line of enquiry 5 and 6).

8.5 Information regarding Mark’s disclosure to his GP of wishing to self-harm and hurt others led to a referral to a talking therapy provider. There was no evidence of consideration of referral to the mental health crisis team which would have been the appropriate intervention. There was also no evidence of considering the potential harm to others or safeguarding consideration of his immediate family. The GP records had no genogram of family makeup though did record another person living with Mark (who was his child that he cared for). (Terms of reference – key line of enquiry 7)

8.6 High levels of consistency in accounts of the brother’s relationship from family, close friends and Gerald’s partner indicated that there was no evidence or information which may have indicated that there was coercive or controlling behaviour, abuse, or violence in the relationship between the brothers prior to the homicide. (Terms of reference - key line of enquiry 8). There were likewise no accounts of violence to other family members though whilst “delusional” Mark had been abusive to his mother via phone messaging in the period leading up to the homicide.

8.7 Mark had a history of violent offending including domestic abuse perpetrated to 2 former partners.

8.8 It is of note that the 3 incidents previously described in this report occurred 12 years prior to the homicide and there were no police or other agency accounts of violent behaviour in the period following that until the homicide.

8.9 Mark was a single parent bringing up a child and no concerns regarding his parenting were evidenced.

8.10 Mark was a user of cannabis and he indicated that this developed into use of synthetic based drugs known as New Psychoactive Substances (NPS) which have risks associated with impact on mental health including psychosis and extreme violent behaviours. Evidence indicated that Mark had been suffering a decline in his mental health for some months prior to him

disclosing to his GP in May 2020. There were no indications that he had previously accessed support. By his own account Mark had withdrawn from social circles for the previous 2 years (Terms of reference – key line of enquiry 9).

8.11 Forensic Psychiatrists agreed that Mark had been experiencing delusions and psychosis at the time of the homicide which were likely to have been affected by his use of NPS. Whilst on remand the delusions abated, and Mark confirmed there was no truth in the allegations he believed to be true whilst under the influence of NPS.

9. LESSONS TO BE LEARNED

9.1 **New Psychoactive Substances** are a relatively recent phenomenon, and the drugs and their harms can rapidly change. The evidence of the impact on some users in terms of violence and psychosis is stark and requires continued effort from agencies in prevention and responding to the issue. Agencies need their professionals to be aware of these risks.

9.2 In December 2021 the Government launched its 10-year strategy to tackle the harms associated with drugs[6]. The strategy was followed with guidance for delivery published in June 2022[7] and the creation of new locality Combatting Drugs Partnerships.

9.3 In Cumbria the Combatting Drugs Partnership is being developed and its links to Safer Cumbria Partnership are under discussion and a comprehensive needs assessment must be completed by November 2022. This can bring together intelligence regarding the availability and impact of NPS in Cumbria and a recommendation is made in this regard (recommendation 1).

9.4 **Safeguarding** – when professionals have disclosure of safeguarding concerns relating to an expressed wish to harm others these need to be explored fully, with risks to community, family and children fully assessed. Where possible agency records should assist in that process and whilst understanding that information may not be held on family makeup on health records it should be considered in assessment or if known recorded on the patient record. The report makes 2 recommendations in this regard (recommendations 2 and 3).

[6] https://www.gov.uk/government/publications/from-harm-to-hope-a-10-year-drugs-plan-to-cut-crime-and-save-lives

[7] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1083170/Guidance_for_local_delivery_partners_FINAL.pdf

9.5 **Inter family abuse and homicide** - domestic homicides in an inter-family context may be less prevalent than homicides of intimate partners or former intimate partners, but nonetheless, should feature within training and development for professionals. This is particularly relevant in respect of the recent statutory definition of domestic abuse as defined in the 2021 Domestic Abuse Act[8] which includes parties who are related. The Review therefore makes a recommendation to ensure that local agencies provide assurance that abusive behaviour between relatives is clearly articulated in training and procedures (recommendation 4).

9.6 Additional single agency learning was identified during this review process via the CCG/GP internal agency review and those recommendations are in the process of being implemented.

10. RECOMMENDATIONS FROM THE REVIEW

Recommendation 1
Safer Cumbria (Combatting Drugs Partnership) to ensure that the 2022 drugs needs assessment considers the profile of New Psychoactive Substances to assist in informing the design of local strategies to support the reduction of serious violence and associated harms.

Recommendation 2
That when risk of harm to others is indicated by patients to health practitioners, assessment of who may be at risk should be routinely considered.

Recommendation 3
That where it is possible to do so, health agencies should consider whether records can indicate key family information and as a minimum childcare responsibility.

Recommendation 4
West Cumbria Community Safety Partnership to ensure that domestic abuse training reflect inter family violence as well as intimate partner violence.

[8] The Domestic Abuse Act 2021 received royal assent on 29 April 2021

Appendix 1: Terms of reference

The Review will work to the following Terms of Reference:

1) Domestic Homicide Reviews (DHR) place a statutory responsibility on organisations to share information. Information shared for the purpose of the DHR will remain confidential to the panel until the panel agree what information is shared in the final report when published.

2) To explore the potential learning from this domestic homicide and not to seek to apportion blame to individuals or agencies.

3) To review the involvement of each individual agency, statutory and non- statutory, with Gerald and Mark.

4) Stuart Douglass has been appointed as the Independent Chair and Author for this review.

5) Members of the Panel are as follows;
   a) Allerdale District Council
   b) Cumbria Constabulary
   c) Cumbria County Council
   d) Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
   e) Eden District Council (Cumbria DHR Coordinator)
   f) Her Majesty's Prison and Probation Service
   g) Humankind (Substance Misuse Provider)
   h) Independent Chair/Author
   i) Lancashire and South Cumbria Care Foundation Trust
   j) NHS North Cumbria Clinical Commissioning Group
   k) North Cumbria Integrated Care NHS Foundation Trust
   l) North West Ambulance Service

5) The Panel to consider where necessary any specialist advice to support the Review.

6) For each contributing agency to provide a chronology of their involvement with Gerald and Mark during the relevant period.

7) For each contributing agency to search all their records outside the identified time periods to ensure no relevant information was omitted and secure all relevant records.

8) For each contributing agency to provide an Individual Management Review: identifying the facts of their involvement with Gerald and Mark, critically analysing the service they provided in line with the specific terms of reference; identifying any recommendations for practice or policy in relation to their agency.

9) To critically analyse the incident and the agencies' responses to the subjects, this review should specifically consider the following points:

- To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to identify and respond to disclosures of domestic abuse.
- To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result.
- To improve inter-agency working and better safeguard adults experiencing domestic abuse.

10) Agencies that have had no contact should attempt to develop an understanding of why this is the case and whether there are actions that could have brought Gerald and Mark in contact with their agency.

11) To sensitively involve the family, friends and where possible the informal networks of Gerald and Mark in the review.

12) To consider an approach to the perpetrator to inform learning.

13) To ensure at all stages of the process that as far as possible the "voice" of Gerald is reflected in submissions to this review.

14) To co-ordinate and have due regard with any other relevant parallel review processes.

15) To establish a clear action plan for individual agency implementation because of any recommendations.

16) To establish a multi-agency action plan in relation to any learning and improvement arising out of the Overview Report.

17) To provide an executive summary.

18) To conduct the process as swiftly as possible, to comply with any disclosure requirements, and on completion, present the full report to the West Cumbria Community Safety Partnership.

Scope of the Review

i. **Time period – June 2019 – June 2020**

The panel decided that the review Individual Management Reviews, information reports and overview report should focus on the period 12 months prior to the homicide with chronologies to cover 5 years, (except for Police and Probation who have specific dates to consider shown below).

ii. **Individual management reviews (IMR) and other reports in respect of the subjects**

Individual management review or information reports to be requested from the following organisations:

- General Practitioner – Solway Health Services

Chronology and information reports will be requested from additional organisations as follows:

- Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

- Cumbria Constabulary
- Her Majesty's Prison and Probation Service
- Department of Work and Pensions
- North Cumbria Integrated Care NHS Foundation Trust
- North West Ambulance Service
- Riverside Housing

All chronologies, individual management reviews and information reports should be completed and returned by the following dates - **IMRs and information reports to be submitted by 11th April 2022**

All individual management reviews and information reports should focus on events from 01/06/2019 up to the date of the discovery of the homicide in June 2020. If, however, any agency has relevant information outside of this period (both prior to and post death if applicable), this information should be included in the individual management review or information report. Furthermore, these dates may change if it becomes apparent to the Independent Chair that the timescale in relation to some aspect of the review should be extended.

All agencies should include all relevant information about both Gerald and Mark.

The review will consider all protected characteristics, as defined by the Equality Act 2010. The review will consider any additional vulnerabilities relevant to the individuals concerned. At the outset, disability has been identified as relevant to this review.

iii. Key lines of enquiry

The review should address both the 'generic issues' set out in the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) and the following specific issues identified in this case:

1. To describe and analyse the events which led up to the fatal incident.

2. To establish an understanding of agency involvement with Gerald and Mark in the 12 months prior to the homicide.

3. Were services responsive and accessible to Gerald?

4. Were services responsive and accessible to Mark?

5. Were any service responses to the subjects affected by the COVID19 pandemic (review each contact/response with current impact at that time)?

6. Was information shared in a timely manner and to all appropriate partners during the period covered by this review?

7. To explore whether there is any evidence or information which may indicate that there was coercive or controlling behaviour or abuse in the relationship.

8. To examine whether there is anything in the perpetrator's background which might explain his character and his behaviour which led to the homicide.

9. Are there areas that agencies can identify where national or local improvements could be made to the existing legal and policy framework?

iv. **Specific issues for individual agencies -** National Probation Service and Cumbria Police to provide any relevant earlier offending history contact regarding Mark.