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The Executive Summary report of the Independent Investigation can be found here.

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There was one national recommendation and a further seven local recommendations which arose from this Domestic Homicide Review. See overleaf for a summary of recommendations.

Lack of care coordination, full information sharing and a robust multi agency approach to risk management.

Lack of full exploration of concerns being raised by the family, and lack of consideration given to further support that they may have needed.

Michael's 'invisibility'

Lack of consideration given to the interplay between Michael's behaviour and his internet use

1

Safer Northumberland Partnership conducted a Domestic Homicide review into to the death of 'Sarah' (aged 45), who was killed in November 2015, by her sixteen year old son "Michael". The report was published in February 2018. The criminal investigation concluded in April 2016 and "Michael" pleaded guilty to manslaughter on the grounds of diminished responsibility and was given an indefinite hospital order.

2

A number of parallel processes were conducted during the period of the review. Northumbria Police undertook a review of their management of the case and The Northumberland Tyne and Wear NHS Foundation Trust undertook a Serious Incident (SI) Investigation in line with Department of Health requirements when a serious incident occurs.

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Domestic Homicide Review 'Sarah'

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The review highlighted a number of key areas for agencies to learn from.

These included:

Inadequate assessment and treatment of "Michael's" mental health.

Failure to identify domestic abuse, specifically Adolescent to Parent Violence and Abuse, and to fully recognise the risk posed by "Michael".

NSCB APVA Guidance here

The findings from the review highlighted a number of key areas for learning both on a national and local footprint. See next two areas for a summary of key learning

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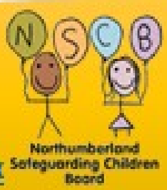
In addition, NHS England commissioned an Independent Investigation to meet the requirements of the DHR in accordance with the wider scope of the SI framework 2015.

4

http://www.northumberland.gov.uk/Children/Safeguarding.aspx



Summary of recommendations arising from this review

National Recommendation:

- Home Office/Safe lives to consider the current definition of domestic abuse and the age criteria for referral into MARAC, in light of the learning from this review, and identify whether this can be amended to reflect issues in relation to APVA.

Local recommendation 1 (for all agencies involved in the review):

- All agencies to ensure that the Home Office document relating to APVA is disseminated to all relevant staff, and that the key learning and guidance within this is incorporated into relevant existing training around domestic abuse, Safeguarding, risk assessment and management.

Local recommendation 2:

- Safer Northumberland Partnership to coordinate a piece of work to identify the most appropriate referral pathways in future cases of APVA, and for this information to be disseminated to staff within all agencies.

Local recommendation 3 (for all agencies involved in the review):

- All agencies to ensure that all relevant staff are aware of the need to make Safeguarding referrals, even when other agencies are already involved or it is believed concerns have already been raised.

Local recommendation 4 (for all agencies involved in the review):

- All agencies to ensure that where other agencies are identified as part of a strategy to manage risk, full and appropriate information is shared to the relevant agency to ensure an appropriate response.

Local recommendation 5 (for all agencies involved in the review):

- All agencies to review current practice to ensure that parent's views, and those of other relevant family members or carers, are taken into account within assessments, that they are being offered the opportunity to be seen alone, and that carers' assessments and/or signposting or referral to support services are being offered.

Local recommendation 6 (for all agencies involved in the review):

- All agencies working directly with children to ensure that workers are equipped with skills and tools to actively seek and record the views of children and to incorporate these into assessments and accompanying plans. To ensure also that those providing supervision for staff robustly challenge whether children's views have been sought and recorded.

Local recommendation 7 (for all agencies involved in the review):

- All agencies to ensure appropriate training is provided to staff regarding the potential risks associated with internet use, particularly in relation to the interplay with mental health issues, vulnerability and issues of radicalisation. To ensure that such consideration of such issues are prompted in any risk assessments undertaken.