DOMESTIC HOMICIDE REVIEW CASE 3:

EXECUTIVE SUMMARY

MAY 2014

Safer Devon Partnership

INTRODUCTION

1. This report of a domestic homicide review undertaken by the Safer Devon Partnership (SDP) on behalf of Safer North Devon Community Safety Partnership (CSP) is to review the death of Subject A, who was killed by her husband Subject B in Devon in September 2011. Subject B was convicted of manslaughter on 12th July 2012 and is serving a prison sentence of 12 years.

2. The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future. The report examines engagement between agencies and Subject A, Subject B and their household prior to Subject A's death.

3. The review was conducted by a panel with an independent chair and representatives of :
    - Devon County Council
    - Devon & Cornwall Police
    - NHS Devon
    - Adva (Against Domestic Violence and Abuse Partnership).

    The Independent Chair has knowledge of community safety, partnerships and domestic abuse, has never been employed by any of the agencies concerned with this review, and has no personal connection to any of the people involved in the case.

4. The review report draws on information and analysis from the agencies which were potential support agencies for Subject A prior to her death. A number of local agencies checked their past contacts with Subject A and her household. Relevant records of involvement were identified by the County Council, police and health services.

5. The review was initiated in September 2011, in the light of a joint chronology of contact with the family. The confirmation of terms of reference and preparation of individual management reviews (IMRs) by agencies was deferred until after criminal proceedings were completed in July 2012. IMRs were prepared by Devon & Cornwall Police, Devon County Council (Vulnerable Adults Service), Northern Devon Healthcare Trust (NDHT), Devon Partnership NHS Trust (DPT) and the Child and Adolescent Mental Health Service (CAMHS). The panel drew up an overview report based on these, other information about local services and conversations with family and friends of the victim. This was submitted to the Home Office for quality assurance in November 2013, approval received in April 2014.[1] The overview report is available to the agencies responsible for

[1] A copy of the letter from the Home Office confirming this is available via the SDP website.

responding to domestic abuse, but is not in the public domain to protect the privacy of the victim's children and elderly relative.

CIRCUMSTANCES OF THE HOMICIDE

6. The family home was a large property in an isolated rural location. Subject B held a firearms license and a shotgun licence. He killed Subject A with an illegally held firearm, which had been hidden on the property. She had recently moved out of the home, and was there to return a child who still lived there.

7. The household consisted of Subjects A and B, their children, aged between 7 and 17, and an elderly relative. The homicide occurred at the end of a week of crisis in the family, during which Subject B discovered that Subject A had formed a relationship with another man. Amid the turbulence, there was altercation between Subject A and her eldest child (Boy D) during which Subject A hit the boy. Over the next few days Subject A moved into temporary accommodation nearby with Subject C, but returned at various times.

8. During the week Subject B was taken to North Devon hospital with chest pains, and subsequently received a psychiatric assessment. While in hospital he spoke to a police officer, making allegations about Subject C. These resulted in police visiting him at home to obtain more information on the day before the homicide. He also told police of Subject A's having hit Boy D.

CONCLUSIONS AND RECOMMENDATIONS

Was there a record of domestic abuse?

9. There were no reports to any public or voluntary agency of Subject A experiencing domestic violence or any other form of domestic abuse from Subject B prior to the homicide, or of reported incidents that should have been recognised as such abuse. No evidence of previous physical assault was provided at the trial.

10. As a result of problems with the children's health, professionals from health and education services had observed the couple together on a number of occasions over the period 2000 to 2003 and 2006 to 2011. These were staff trained to be alert to the possibility of domestic abuse, and several of them saw Subject A on her own. Their assessment was that this was a family with complex needs who were managing these to the best of their ability, and that there were no indications of domestic abuse.

11. There is, however, clear evidence from friends and family that Subject B's relationship with Subject A could be controlling, although not that there was coercion involved. Neither Subject A herself, nor others in contact with the family, perceived this as domestic abuse.

Could the homicide have been predicted or prevented?

On the day

12. There was no opportunity for intervention on the day of the homicide. No public agencies visited the household that day, and no calls for help were made until after the killing.

During the previous week

13. Although several agencies became aware that Subject A had left Subject B , and of the resulting tension within the household, the homicide could not have been predicted by them either singly or together. Subject B presented to them as concerned about the safety of his children, rather than threatening Subject A, who had moved out of the house. They did not have information about the controlling nature of the relationship.

14. No agency was in a position to realise the extent of the threat to Subject A, or to have a reason to use the DASH[2] risk assessment tool. However, there were points at which an alternative sequence of events could have been triggered had agencies not made what in other circumstances would have been minor errors. These were as follows:

    (a) Recording errors and communication delays by police meant that no response had been made by the time of the homicide to their learning, 4 days earlier, that Subject A had hit Boy D. As he was not yet 18, this should have been investigated promptly as an assault by an adult on a child. There would then have been more police interaction with the family, including Subject A. This might have led to a fuller picture of the degree of tension and threat in the household. Whilst the focus would have been on safeguarding Boy D, interviews with his mother might have provided a fuller picture of potential risk to her.

    (b) There was incomplete communication between the police officer who spoke to Subject B in the hospital, the Northern Devon Healthcare Trust ward staff and the Devon Partnership NHS Trust Psychiatric Liaison Team. This meant that, while the psychiatric assessment looked at whether Subject B might pose a risk to himself or others, it did so without knowledge of concerns raised on the ward. These concerns were not substantial enough in themselves to trigger any intervention, but it is possible that Subject B would have revealed more if they had been explored during the assessment.

15. The police had sufficient grounds on the basis of Subject B's mental state, even without evidence of a direct threat, to seize the legally held firearms from his home on or after his admission to hospital, but did not consider this. This would not have directly prevented the homicide, which was carried out with the illegally

[2] DASH – domestic abuse, stalking and harassment, is a nationally approved tool available to all agencies in Devon.

held weapon. It is impossible to say whether it would have indirectly affected the outcome by changing the subsequent behaviour of any party.

Before the final week

16. There were domestic abuse services available in North Devon which could have provided advice to Subject A to help her respond to the controlling relationship with Subject B, and to plan for her own safety if she chose to end the marriage. She lived in a remote rural area which may have made it harder for her to access support and may have led to her feeling isolated from help. However, these services were publicised where she worked, and she had friends who were familiar with their role. She had her own phone and car, and drove independently to work, so had the means to access them. It is not possible to be sure why this did not happen, but it seems likely that she did not think of the relationship as abusive or recognise the risk she ran in leaving.

17. A number of professionals had regular contact with Subject A in the years before the homicide: her GP and medical staff at NDHT, her colleagues where she worked, a Parenting Support Worker, the CAMHS team and staff of services caring her elderly relative. None of these witnessed abuse by Subject B, and some consciously offered Subject A the opportunity to disclose any concerns. There is no indication that any of them could or should have intervened in a way that would have prevented the homicide.

What can be learned to improve future practice?

18. Subject B's relationship with Subject A included elements of control, and ended in him killing her when she was leaving him. Raising awareness that domestic abuse is about misuse of power, and includes emotional abuse and controlling behaviour, whether or not there is physical violence, remains important. Public understanding of this appears patchy. In particular, it is important to draw attention to the increased risk of harm at the time of separation.

19. Subject A did have access to information about domestic abuse services, despite living in a very rural setting. Her isolated location, in a household that – as is common in rural Devon – had a legitimate use for guns, may have added to the risk she faced. Continuing efforts should therefore be made to ensure messages about domestic abuse reach all parts of the community.

20. The homicide was the end point of a week of tension in a complex family. Several agencies were drawn into this at different points. While all tried conscientiously to meet the need of the family member who asked their help, none saw or sought the whole picture. As Subject A did not seek help, the risk to her remained hidden. While it is unlikely that, in this case, agencies could have discovered enough to prevent the killing, it underlines the importance of the "think family" approach.

21. The case illustrates the danger posed by access to guns during times of household stress, particularly where there is domestic abuse. Although the

homicide was committed with an illegally held firearm, it remains important to consider removing legally held weapons. The police have adequate protocols for this, but may not have information about risks known to health services. In this case the police officers who visited the house were not aware that Subject B was being treated by DPT. New national arrangements for sharing information about firearms licences with GPs will be helpful when fully implemented.

22. The review has identified some good practice in the agency approaches to domestic abuse. These include the training given in schools, creative approaches to publicizing domestic abuse services in rural areas, and the existence of an independent specialist domestic violence and abuse service providing support to victims and children and working closely with statutory agencies. It also found front line staff being proactive in responding when hearing a service user say something of concern. Despite changing structures over the years, the CAMHS service had clear records and recollections of their approach, which aimed to take account of the whole family context. While the main hospital in the area, NDHT, did not routinely ask obstetrics and gynaecology patients about domestic abuse when Subject A attended several years ago, it does now.

23. In the course of the review, agencies found examples of staff not fully following standard procedure, including examples of records not fully completed. For example, it is not clear whether Subject A had never been offered, or had declined, a carer's assessment. Our recommendations underline the importance of ensuring that good practice is followed as well as written into policy.

24. Some lessons from this investigation have already been implemented:
    (a) Following the Root Cause Analysis report by DPT:

        i. NDHT makes referrals to the DPT Psychiatric Liaison team in writing, using a new form;

        ii. DPT have confirmed that their procedures for checking quality of clinical records do cover patients seen only once;

        iii. Work has been done with the teams concerned to learn from the incident, including underlining the importance of quality of records.

    (b) Devon and Cornwall Police have initiated programmes of regular internal messaging to remind officers about the circumstances under which licensed firearms can be seized and 121A process for reporting incidents involving young people. Local follow up of the national ruling, given in 2013, that police should treat 17 year olds as children in all circumstances (including arrest) has helped to reinforce this second point.

RECOMMENDATIONS

25. These recommendations include ways to continue good practice found in this case, as well as addressing areas where services could have done better.

- **R1 Health, social care staff or other related services working with any member of a family in which there appear to be significant stresses (for example due to mental illness, learning disability, or substance misuse) take opportunities to consider the whole family situation and be alert to any indicators of domestic abuse.**

- **R2 Review, and if necessary amend, the protocols for information sharing between the police and health care providers in Devon relating to situations where they are simultaneously working with the same person.**

- **R3 Ensure that there are effective nationally agreed arrangements for police and health care providers to share information on people holding or applying for firearms licences.**

- **R4 Maintain a variety of means of raising awareness among the public and front line staff in rural areas of the nature of domestic abuse, and of the help available. This should include awareness that abuse includes coercion and control as well as violence, and that the new definition covers 16 and 17 year olds as well as adults.**

- **R5 Ensure staff of all agencies are aware of the importance of accurate recording of information and application of information sharing protocols.**

- **R6 Review arrangements for provision of domestic violence awareness training, including coverage of coercive control, to staff working within Devon County Council's Care Direct and Complex Care Teams.**