Safer Communities Torbay

Domestic Homicide Review

Executive Summary

DHR02

Report into the death of Mrs A in March 2013

Communicated to the Home Office: 31 July 2014

Safer Communities Torbay is a statutory multi-agency partnership which includes:

Torbay Council, Devon and Cornwall Police, Devon and Cornwall Probation Trust, Devon and Somerset Fire and Rescue Service, Torbay's Youth Offending Team and the NHS

Safer Communities Torbay

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Report produced by Bob Spencer – Independent Domestic Homicide Review Panel Chairman and Vicky Booty – Project Manager Safer Communities Torbay

Opening statement

This summary outlines the process undertaken by Torbay's Domestic Homicide Review Panel in reviewing the tragic death of Mrs A, who was killed by her husband (Mr B) in March 2013. The process began with an initial meeting on 22 July 2013 of agencies that potentially had contact with Mrs A prior to her death.

The fundamental purpose of Domestic Homicide Reviews (DHRs) is to review events, circumstances, systems and process, and to consider what improvements could be made to the way in which statutory agencies and other organisations work, to prevent such deaths from happening again.

A DHR is a process in itself and sometimes within processes (especially within formal documentation such as this) there can be a tendency for the 'human element' to become lost. As such the Review Panel wish to acknowledge from the outset of this report that Mrs A was an individual and her death has had a profound impact on her family and others. Whilst the review in itself may not bring comfort to those individuals directly involved, it is the Review Panel's intention that learning can be found and shared from such a tragedy.

The Review Panel would like to formally thank the family of Mrs A for their support and patience with this review and acknowledge that their contribution has been an invaluable part of the process. The Panel also extend thanks to an individual related to the perpetrator and others associated with this review.

This document provides an Executive Summary of the Overview Report associated with this DHR. The information contained within this document is fully anonymised in accordance with Statutory Guidance.

Background to the review

On 12 March 2013 Safer Communities Torbay, Torbay's Community Safety Partnership (CSP), received a referral from Devon and Cornwall Police for the consideration of a Domestic Homicide Review (DHR). A core group of senior officers and the CSP Chair, in consultation with members of the CSP, agreed that the referral met the requirements for a DHR as set out below:

> *A review of the circumstances in which the death of a person **aged 16 or over** has or appears to have, resulted from violence, abuse or neglect by:*
>
> *(a) a person to whom he/she was related or with whom he/she was or had been in an intimate personal relationship.*

This was the first DHR to be carried out in Torbay by Torbay's CSP (called Safer Communities Torbay). The review was carried out in accordance with the Home Office guidance and section 9 (3) of the Domestic Violence Crime and Victims Act 2004.

At the time of the review criminal proceedings had been completed and Mr B was found guilty of the murder of Mrs A.

DHRs were introduced by the Domestic Violence, Crime and Victims Act (2004) which came into force on 13 April 2011. They aim to establish what lessons are to be learned from domestic homicide about the way local professionals and organisations work, individually and together, to safeguard victims. This should help prevent such deaths and improve service responses for all domestic violence victims and their children. DHRs are not inquiries into how the victim died or into who is culpable, nor are they part of any disciplinary process.

Purpose of this review

This review had the following purpose:

- To establish the sequence of agency/organisation contact with Mrs A. This includes identifying any recorded incidents of domestic abuse and violence between Mrs A and her husband.
- To invite the involvement of the family (and, if appropriate, friends) of Mrs A and Mr B, to provide a robust analysis of events.
- To consider whether, under the circumstances, agency intervention potentially could have, or would not have, prevented the victim's death.
- To provide a report which summarises the chronology of events, analyses and comments on the actions of the agencies involved, and makes any required recommendations for improving the way agencies, singly and together, respond to domestic abuse.
- To identify how and within what timescales any recommendations will be acted on, and what is expected to change as a result.

Definition of domestic violence and abuse

In March 2013, the Government introduced a new cross-government definition of domestic violence and abuse, which is designed to ensure a common approach to tackling domestic violence and abuse by different agencies. The new definition states that domestic violence and abuse is:

"any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:

- *psychological*
- *physical*
- *sexual*
- *financial*
- *emotional*

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

This definition, which is not a legal definition, includes so-called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group[1].

[1] Source - Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (revised 1 August 2013)

The process of this review

Agencies participating in this review included:

- South Devon Healthcare NHS Foundation Trust
- Devon Partnership NHS Trust
- Torbay and Southern Devon Health and Care NHS Trust
- Devon and Cornwall Police
- General Practitioners
- Independent Domestic Violence Advisor Service Torbay Council
- Children's Social Care Torbay Council
- Family Solutions Service Torbay Council

Agencies were asked to give chronological accounts of their contact with the victim prior to her death. Where there was no involvement or insignificant involvement, agencies advised accordingly. Statutory Home Office guidance for the conduct of Domestic Homicide Reviews states that agency report should cover the following:

> *A chronology of interaction with the victim and/or their family; what was done or agreed; whether internal procedures were followed; and conclusions and recommendations from the agency's point of view.*

Summary of agency contact with Mrs A

Organisation	Status	Context
South Devon Healthcare NHS Foundation Trust (Torbay Hospital)	Known to service	No contact since 2000.
General Practitioner	Known to service	2000 diagnosed with depression associated with significant life events. 2001 Prescribed medication for depression. 2001 Vasovagal diagnosed. 2002 Cervical Sponylosis diagnosed. 2003 Referred for counselling but discharged (April to June 2003) 2005 Change of medication. Monthly reviews moving to three monthly reviews between 2005 and 2007. 2009 Foot/joint pain treated.
Torbay and Southern Devon Health and Care NHS Trust	Known to service	Contact in 2009 based on GP request.
Independent Domestic Violence Advisor Service	Not known to service	Not applicable
Devon Partnership Trust	Not known to service	Not applicable
Children's Social Care	Not known to service	Not applicable
Family Solutions Service	Not known to service	Not applicable
Devon and Cornwall Police	Not known to service	Not applicable

Summary of agency contact with Mr B

Organisation	Status	
South Devon Healthcare NHS Foundation Trust (Torbay Hospital)	Known to service	Until incident, no contact since 2011.
General Practitioner	Known to service	Dec 2012 Alcohol screening and intervention, referral to specialist alcohol service. Dec 2012 Patient seen at surgery, consultation indicated low mood. Nov 2012 Apr 2012 Alcohol screening Dec 2011 Alcohol screening and intervention Various appointments during 2010 relating to heart health.
Torbay and Southern Devon Health and Care NHS Trust	Not known to service	Not applicable
Independent Domestic Violence Advisor Service	Not known to service	Not applicable
Devon Partnership Trust	Not known to service	Not applicable
Children's Social Care	Not known to service	Not applicable
Family Solutions Service	Not known to service	Not applicable
Devon and Cornwall Police	Not known to service	Not applicable

Usually a method of obtaining information from agencies and organisations for DHRs is through Individual Management Reviews (IMRs). An IMR is a process of review resulting in a document which the review panel can then consider.

The aim of an IMR is to:

- allow agencies to look openly and critically at individual and organisational practice and the context within which people were working to see whether the homicide indicates that changes could and should be made
- to identify how those changes will be brought about
- to identify examples of good practice within agencies

To find out more about IMRs please refer to page 18 of the Home Office Statutory Guidance[2] which can be viewed online.

An IMR template was produced to support those tasked with completing reviews and associated documentation. However due to the extremely limited nature of agency involvement identified with Mrs A and Mr B, and based on the review panel's assessment of initial information and chronologies received, no

[2] www.gov.uk/government/uploads/system/uploads/attachment_data/file/209020/DHR_Guidance_refresh_HO_final_WEB.pdf

IMRs were requested or completed as part of this review. The panel was of the view that requesting IMRs would be inappropriate and disproportionate to this review. Instead the panel deemed it more appropriate to gather information via discussions which were held with family members of both Mrs A and Mr B, Devon and Cornwall Police, the General Practitioners for Mrs A and Mr B the perpetrator.

Contributors to this Review

After requesting that agencies provide chronologies and a summary of their involvement with Mrs A and Mr B it became apparent to the Review Panel that very little information was available. Due to this the panel was of the view that commissioning the production of Individual Management Reviews (IMRs) would not add any value to the DHR process. Instead the panel believed that utilising aspects of other systems methodology would be prudent and decided to collate information via discussions with relevant individuals (including General Practitioners).

The family of the victim, the family of the perpetrator and the perpetrator himself were all provided with, and accepted, the opportunity to contribute to this review.

The Review Panel

Name	Title	Agency/Organisation
Bob Spencer	Chairman of the Review Panel and Overview Report Co Author	Independent
Delia Gilbert	Safeguarding and Patient Safety Lead	South Devon and Torbay Clinical Commissioning Group
Sophie Creed	Serious Case Review / Domestic Homicide Review	Devon and Cornwall Police
Elaine Atkinson	Child in Need Service Manager	Torbay Council
John Tucker / Shelley Shaw	Supporting People	Torbay Council
Jude Pinder	Alcohol Service Manager	Torbay Drug and Alcohol Service
Vicky Booty	Project Manager (supporting the Review Panel and Co Author)	Torbay Council (Torbay Community Safety Partnership)

Ensuring independence of the review

Bob Spencer, Independent Chairman of Torbay DHR Panel is the principal associate for a Global Multi Agency Crisis Management Company. A post he commenced on concluding a distinguished 30 year career in the Police Service in the rank of Assistant Chief Constable. He is an experienced and nationally trained Senior Investigating Officer and has received international recognition for his command of critical incidents. His current work includes supporting Strategic Team Leaders in Global Companies, developing their multi agency skills in major-incident, business environments, media management and organisational reputation awareness.

Bob has commissioned and chaired more than a dozen Serious Case Reviews. He is currently the Independent Chair of Torbay and Devon Safeguarding Adult Boards. He is a serving Justice of the Peace.

Key issues arising from the review

Mrs A and Mr B had both worked throughout most of their marriage. After the deaths of Mr B's mother and brother (both of which were described as devastating) Mr B and Mrs A had received a sum of money from the sale of the family home. At this time Mr B and Mrs A had given up work due to a variety of factors so were not in receipt of an income.

Mr B and Mrs A did not use the funds to purchase another property for themselves. Instead the funds from the sale of family home were used by Mr B and Mrs A to pay for rented accommodation, utilities and other costs such as food, shopping and alcohol. Whilst outwardly Mr B and Mrs A may have appeared to be financially comfortable their financial position was not sustainable. At the time of Mrs A's death, their joint finances stood at £2,000.

Mr B and Mrs A had become isolated from their families over a lengthy period of time.

Alcohol and mental health

The panel has learnt that during the earlier years of their marriage Mrs A and Mr B enjoyed occasional alcohol within the social setting of licensed premises where other activities were available (for example playing darts). Later Mrs A and Mr B stopped enjoying alcohol within an external social setting and began drinking purely at home and Mr B reflects that it was at this point alcohol started to become a significant issue for him especially. For Mr B it would appear that alcohol was used perhaps to help him cope with bereavement (initially) and later with his concerns about their financial situation. The panel recognise that many other individuals are likely to be using alcohol in the same way. This raises a large question in relation to alcohol use which requires a partnership response.

If alcohol is used by many as a form of 'self medication' for something else, likely to be their mental health, we know that individuals may care little about the implications for their health. As such it's unlikely that a traditional 'health' intervention may help in isolation. Like the recognition that others in addition to the police have a responsibility to tackle crime and disorder (hence the introduction of Community Safety Partnerships), the panel recognise the need for a partnership approach to the incredibly complex issue of alcohol use. The panel suggest that this issue is explored further within Torbay's future strategic planning around alcohol (e.g. within Torbay's Alcohol Strategy).

The panel also note that recent NICE Public Health Guidance (50) on domestic violence and abuse contains reference to alcohol throughout, and that for example within training 'a **universal response** should give staff a basic understanding of the dynamics of domestic violence and abuse and its links to mental health and alcohol and drug misuse, along with their legal duties[3]'.

The guidance goes on to state 'The role played by alcohol or drug misuse in domestic violence and abuse is poorly understood. Research has indicated that 21% of people experiencing partner abuse in the past year thought the perpetrator was under the influence of alcohol and 8% under the influence of illicit drugs (Smith et al. 2012). People are thought to be at increased risk of substance dependency as a consequence of being the victim of domestic violence (Humphreys et. al. 2005)[4].

[3] Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively – NICE February 2014

[4] Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively – NICE February 2014

Engaging with 'the unengaged'

Mrs A and Mr B led an insular and relatively isolated lifestyle, not seeking support for their concerning financial situation and in the case of Mr B choosing not to engage with services to help tackle his drinking behaviour. The panel cannot say if domestic abuse featured within the relationship of Mrs A and Mr B as no evidence has been reviewed to suggest it did. The question of a possible 'suicide pact' was suggested during the course of the investigation but no information considered by the panel at any stage during the review process was found to corroborate that.

Outwardly Mrs A and Mr B gave an impression of being financially solvent and pleasant but quiet individuals with a comfortable lifestyle. Whilst there has to be recognition that some individuals will never seek support, no matter what their circumstances, for agencies this opens a wider conversation. What more can we do to identify and support those who may not necessarily come to our notice? How could we work differently to reach out to the hidden vulnerable? Can we communicate about our services differently? Can we make ourselves more approachable to those who feel that they cannot, or perhaps should not ask for help?

The panel does not have the answers to these questions, however the conversation is one that needs to be had particularly in the current economic climate where agency resources are diminishing.

Supporting families

Whilst not directly relevant to the remit of the DHR, the panel received information to indicate areas for improvement in the way in which individuals and families are communicated with, following such a tragic and traumatic event.

Processes are vital to keep progress against cases moving, but for those who have never experienced (and would never hope to experience) such events, any involvement in such a process can be incredibly daunting.

The panel recognise that individuals and families touched by such traumatic events must be given the opportunity to fully understand the process ahead, their place within it, what they can influence and control, and what they cannot control.

To be thrust into an alien and highly distressing situation because of somebody else's actions can also be disorientating which is why services provided by organisations such as Victim Support are so incredibly vital to help guide and support individuals and families at the very earliest opportunity.

A dedicated team within Victim Support are able to provide support to the family of the victim in such cases as this. The panel also recognise however that in some circumstances the family of an offender may also need some form of support which could take the form of signposting individuals to services that may be available to them (for example counselling via a local GP).

The panel recognise that a crucial factor in supporting families is regular, consistent, sensitive and timely communication between agencies, organisations and those individuals directly affected.

Conclusions and recommendations

Could the death of Mrs A have been prevented?

Throughout the course of the review no information was considered by the panel that provided any evidence to indicate that the relationship between Mrs A and Mr B was at any time abusive.

The panel did not consider any information that could explain with any accuracy why Mr B acted in the way he did which resulted in the tragic and violent death of Mrs A.

The panel recognise that from the information considered Mrs A and Mr B led an isolated, insular and seemingly comfortable (but not financially sustainable) life, choosing to spend their time exclusively with each other at their rented home whilst maintaining very little communication with their own families.

Mrs A and Mr B appeared to have very few interests other than watching television and reading. From the information considered by the panel, the lifestyle of Mrs A and Mr B appeared to be repetitive and consistent with each day experienced similar to the day before.

The panel consider the regular use of alcohol (i.e. on a daily basis) as a significant factor within the lifestyle of Mrs A and Mr B. Whilst the panel considered information to indicate that Mrs A would drink alcohol, there is evidence that Mr B's consumption was of a higher level that was damaging to his health.

Mrs A and Mr B's finances (based the sale of a property) were quickly diminishing and with no income this would have left them increasingly vulnerable to losing their home and their lifestyle.

Mrs A and Mr B had very little contact with statutory agencies and at no time was domestic abuse ever disclosed.

Due to these factors the panel is of the view that in this case the tragic death of Mrs A could not have been prevented. The panel is also of the view that no person other than the perpetrator Mr B was to blame for the death.

As such the recommendations that follow are based on the panel's general observations relating to the lifestyle of Mrs A and Mr B identified during the course or the review and how in future agencies may be able to adapt to better engage with those who for a number of reasons choose not to seek or accept the support of available services.

Conclusions and associated recommendations

Whilst elements of the lifestyle of Mrs A and Mr B could be perceived by some as 'unhealthy' or 'different' it is not the panel's remit to speculate or pass judgement on how two people chose to live. The panel recognise that over a long period of time Mrs A and Mr B gradually became distant from their families.

The panel are not able to make any medical judgements however recognise Mr B's comments that for a number of years he had suffered with a 'low mood' and that he appeared to have attempted to manage this himself by misusing alcohol. The trigger for this appears to coincide with a number of close family bereavements experienced by Mr B.

The extent of Mr B's misuse of alcohol is recognised as a key feature within the review. Mr B was provided with guidance relating to his alcohol intake however he states that it was his choice to disregard that information. In general terms the panel recognise that discussing alcohol can be extremely challenging as some individuals may not wish to be honest with themselves about how much alcohol they are consuming, or the reasons for their behaviour. This then in some circumstances makes being honest with a professional such as a GP or nurse incredibly difficult.

The panel recognises the complex challenges for GPs in terms of identifying and focusing on one specific element of an individual's behaviour (e.g. harmful drinking). The panel consider that there may be value within

health services of identifying cohorts of individuals who may be at risk and inviting them to take part in 'health checks' whereby their health, wellbeing and lifestyle can be explored in a proactive and non-confrontational way.

Overall these issues are worthy of further debate relating to how (or even if) agencies can work differently to successfully engage with individuals who purposefully and personally choose not to access support and services that could ultimately help them.

Recommendation 1
The panel recommend that the issue of working in a different way to establish effective contact with individuals and families who are recorded as 'unengaged' with statutory services be considered by Torbay's Domestic Abuse Steering Group, and for the results to be communicated back to Torbay Community Safety Partnership. The panel suggest that good practice from other areas be sought to inform discussions.

Recommendation 2
The panel recommend that the issue of grief/bereavement as potential triggers for both mental and physical health in individuals of any age be incorporated into Torbay's Mental Health Strategy, and for this issue to be explored with Torbay and Southern Devon Clinical Commissioning Group.

Like the subject of domestic abuse itself, openly talking about an issue can over time help to remove any stigma associated with it.

Recommendation 3
The panel recommend that with support from the Community Safety Partnership and in partnership with Torbay's Public Health Team, work be completed by Torbay's Domestic Abuse Steering Group to raise awareness through a consistent, sustainable and widespread programme within the community of how alcohol can form part of an individual's coping strategy, along with signposting to relevant support services and;

That local commissioners of drug and alcohol services update the Community Safety Partnership in terms of what action is being delivered with regard to NICE guideline (50) 'Domestic Violence and Abuse: How health services, social care and the organisations they work with can respond effectively'.

Recommendation 4
The panel recommend that mental health as an issue is fully integrated into the development of future Alcohol Strategies for Torbay.

Towards the latter stages of the review, the panel briefly explored alcohol information and advice available on websites such as www.nhs.uk/livewell/alcohol/Pages/Alcoholhome.aspx and www.drinkaware.co.uk/understand-your-drinking/why-do-you-drink, and consider that further work could be done to further publicise how some individuals may use alcohol (consciously or subconsciously) to help them 'cope' with something else in their life. In the case of this review alcohol was a key factor and the panel recognise that the perpetrator had little regard for the health implications of alcohol misuse and that it was perhaps his mental health that was driving his behaviour with alcohol.

Recommendation 5

That at a national level via the Home Office that consideration is given to further openly communicating with the public the links between alcohol and mental health.

The panel is of the view that this type of educational/awareness programme may help individuals to think about what is really causing their behaviour, rather than just considering the behaviour itself.

The panel recognise from that in general terms it may be incredibly challenging for any individual to seek help with domestic abuse due to the intimate nature of the subject. The panel also recognise from sources such as Women's Aid that issues such as hazardous drinking[5] and mental health issues[6] (for example anxiety) may, in some cases, be indicators that a patient is experiencing domestic abuse.

Recommendation 6

The panel recommend that targeted activity is completed in partnership with General Practitioners in Torbay to agree what action in practical terms could be taken to raise awareness of the issue of hazardous drinking and mental health as possible indicators of domestic abuse. The panel also recommend that consideration be given to working across local authority, Clinical Commissioning boundary areas to ensure learning and practice is shared.

It is the understanding of the panel that each GP practice has a Safeguarding Adults and Child Protection Lead(s).

Recommendation 7

The panel recommend that work be conducted to establish if the Safeguarding Adults / Child Protection Leads within General Practitioner Practices could be developed to include domestic abuse (with appropriate training).

During the panel's analysis consideration was given to if, when and how GP's could enquire with their patients if they were experiencing domestic abuse. Routine enquiry is used in a number of medical settings, however the panel recognise that in terms of GPs asking questions relating to a patient's relationship have to be handled incredibly sensitively as it could impact on the therapeutic relationship between a GP and a patient.

Recommendation 8

The panel recommend that the concept of Routine Enquiry or an alternative and practical solution to engage with patients about the safety of their relationship(s) be explored as a key feature within the engagement with GPs as part of recommendation 6.

The panel asked Mr B why at no point did he or Mrs A seek the support of services that may have been able to assist them with their financial situation. Mr B stated that he (and Mrs A) were brought up to be independent and to "stand on their own two feet", were aware that their own actions had resulted in financial difficulties and did not feel able to "go cap in hand" to the council or another organisation. The panel recognise that there are many people who may be in similar financial circumstances and for a range of factors, one of which may be generational, feel that they cannot access services.

[5] http://www.womensaid.org.uk/domestic-violence-survivors-handbook.asp?section=000100010008000100360003
[6] http://www.womensaid.org.uk/domestic_violence_topic.asp?section=0001000100220004&sectionTitle=Mental+Health

Recommendation 9

The panel recommend that Torbay Council reviews how it markets and communicates key services such as Housing Options and Benefits;

And also considers where individuals who have found themselves in vulnerable circumstances may feel more comfortable to seek support or access information, and ensure that appropriate provisions are implemented.

Throughout the course of the review the panel considered information from the family of Mrs A and the family of Mr B which highlighted areas for improvement specifically relating to how individuals and families should be supported following deaths in such circumstances. Whilst this information is not relevant for the DHR itself, the panel has communicated with Devon and Cornwall Police to share areas for development and improvement.

The Home Office Revised Statutory Guidance for the Conduct of Domestic Homicide Reviews states that:

It is important to draw out key findings of DHRs and their implications for policy and practice. The following may assist in achieving maximum benefit from the DHR process.

a) *As far as possible, the review should be conducted in such a way that the process is seen as a learning exercise and not as a way of apportioning blame.*

b) *Consider what type and level of information needs to be disseminated, how and to whom, in the light of the review. Be prepared to communicate both examples of good practice and areas where change is required.*

c) *Subsequent learning should be disseminated to the local MARAC, any local Domestic Violence Forums or similar, the Local Safeguarding Children Board and commissioners of services.*

d) *Incorporate the learning (including any national lessons learnt) into local and regional training programmes.*

e) *The CSP should put in place a means of monitoring and auditing the actions against recommendations and intended outcomes.*

f) *Establish a culture of learning lessons by having a standing agenda item for DHRs on the meetings of CSP and Domestic Violence Forums and similar groups.*

Recommendation 10

The panel recommend that the Community Safety Partnership make arrangements to enable the learning from this review (DHR02) to be disseminated to the local MARAC and the Adult Safeguarding Board for Torbay;

And that the Community Safety Partnership monitor the recommendations and associated actions from the DHR via appropriate means;

And that DHRs feature as a standing item on the Community Safety Partnership's meeting agendas.

The recommendations from the DHR will be monitored and reviewed by Safer Communities Torbay.