Approved by Home Office Quality Assurance Panel September 2014

Safer Somerset Partnership

Feel Safe, Be Safe

Domestic Homicide Review

Executive Summary of the Overview Report

into the death of Ms E
12th October 2013

The Panel send their condolences
to the family of Ms E

B Higgs

Independent Panel Chair and Author

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1. Introduction

This Domestic Homicide Review (DHR) was commissioned by the Safer Somerset Partnership following the death of Ms E on the 12th October 2013.

1.1 Case Summary

At approximately 11pm on Saturday 12th October 2013 ambulance and police services were called to a public footpath at the rear of a local college where they found the deceased who had apparently taken her own life. She was 49 years old.

Although the post mortem found small quantities of multiple substances and alcohol in her system the cause of death was established as hanging.

Earlier that evening Ms E had been engaged in an altercation with Mr D her current partner. He had told her he was intending to leave her. Although their argument had been heated no violence had taken place between them.

Ms E had a long history of drug addiction, a chaotic lifestyle and violence at the hands of partners and her older son who is also drug dependent.

1.2 The Background

Ms E aged 49 was the youngest of three children adopted into one family. The family later had two natural children. She describes to others a happy childhood, in a stable comfortable family life involved in farming. Her mother, four siblings and two sons survive her. Nothing is known about her birth parents other than that they were teenagers. It is known she never wanted to meet them but said she would like to have seen a photograph.

Ms E is described as fun, kind and generous. She was always helpful and had a very caring nature. She loved her children but her drug habit impaired her ability to be effective in their upbringing. In her own way she tried to do her best for them. Towards the end of her life this was to her detriment.

Ms E was said to be attracted to drugs in her teenage years. She 'experimented' as many teenagers do but was never able to break the habit. She started using heroin when she was 21 and used it and other drugs on and off for the rest of her life. She met Mr E who was also a drug user, they married and had a son Mr F in 1991. During the marriage her drug and alcohol abuse escalated. There was violence in this relationship. They subsequently divorced. Mr E maintained a relationship with his son that continues.

Ms E is described as an intelligent caring woman who was highly capable she trained and worked as a nurse. Ms E first came to police attention in 1997 at the age of 33, she was charged with theft from her employer which effectively ended her nursing career. Ms E claimed benefits for a period of time but her family insisted she worked as they felt this would give her some stability. She worked as a cleaner. She was always able to sustain herself but was generally short of money. Her family provided Ms E with a home under the auspices of a Trust. She had five criminal convictions four for theft and one for cultivating cannabis.

At one time Ms E was drug free. She wanted to visit Australia. As Australia will not accept individuals importing Methadone for personal use this provided the incentive for Ms E to get clean which she did successfully. However, on her return to the UK she lapsed back into her habit.

She later met Mr G and had a son G with him in 2005. This was a volatile relationship. They too separated. The son was taken into the care of the paternal grandparents from the age of three months old due to heavy drug use and conflict in the home. Ms E visited her son every Sunday which involved a lengthy journey, she maintained a good relationship with his grandparents. They occasionally supported her financially by providing bus fares.

In 2006 Ms E's father to whom she was close died of cancer and this is said to have affected her deeply, leading to increased drug use.

Ms E's relationship with her older son Mr F was extremely difficult. Mr F is heavily drug dependent with serious mental and physical health issues. In the latter years their relationship was turbulent, including violence in the home putting her in fear. Mr F frequently made suicidal threats. Mr F was living with his mother towards the end of her life and was said to be 'bleeding his mum dry'. However, at the time she died he was reported to be living rough. It is believed that he introduced Ms E to Mr D who was her partner shortly before her death.

Mr D has a long history of criminal activity; 28 convictions for 117 offences which include assault, theft, fraud, public disorder drugs and motoring offences. His relationships were dysfunctional and he was known to MARAC following violence to his ex-wife.

2.0 The Review Process

This summary outlines the process undertaken by the Domestic Homicide Review Panel.

2.1 The DHR advisory group decided that there were sufficient complexities in Ms E's background to suggest that a review in accordance with S.37 of the

Home Office DHR guidelines would be recommended to the Partnership Chair.

The review commenced with an initial DHR Review Panel Meeting on 10th February 2014. The review has been conducted in line with section 9 of the Domestic Violence, Crime and Victims Act 2004 and the expectations of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (revised August 2013). The overview report has been prepared in accordance with the Home Office guidelines (January 2014)

2.2 Agencies Contacted

The following agencies were contacted about this review

Avon & Somerset Constabulary
Avon & Somerset Probation Trust
Chapter 1
IDVA/Bournemouth Churches Housing Association
Mendip District Council
NHS Foundation Trust (Yeovil District Hospital)
SCSC Children's Social Care
Sedgemoor District Council
Somerset Clinical Commissioning Group
Somerset Partnership NHS Foundation Trust
Somerset Safeguarding Adults Board
Somerset Adult Social Care Foundation Trust
Taunton & Somerset NHS Foundation Trust (Musgrove Hospital)
Taunton Deane Borough Council
Turning Point/Somerset Drug & Alcohol Service
Victim Support
West Somerset Council

2.3 Family & Friends

From the start of the review process it was clear that Ms E's older son was vulnerable from the point of view of his drug and substance misuse and mental health. He has been said to have expressed feelings of guilt about introducing his mother to her partner Mr D. For this reason and as agencies were able to provide considerable information about Mr F the panel chair decided not to pursue contact. Her partner Mr D left the home the day after her death and his whereabouts have since been unknown.

Ms E's early background came to light during the review. The Review Panel Chair traced her childhood family and had conversations with two individuals. One extended family member had limited knowledge. A close family member decided after some discussion not to contribute because it was too distressing. The Panel Chair agreed to keep this family member informed concerning the progress of the review.

2.4 Individual Management reviews (IMR)

The following agencies were requested to conduct Individual Management Reviews. .

Avon & Somerset Constabulary
Turning Point/Somerset Drug & Alcohol Service
Somerset Clinical Commissioning Group
Somerset County Council Children's Social Care
Somerset Partnership NHS Foundation Trust

These agencies provided comprehensive data that contributed significantly to the understanding of Ms E's circumstances.

2.5 Purpose of IMR's:

- Provide a chronology of involvement with agencies by Ms E, her son Mr F and partner Mr D for the time period specified. From the chronologies provided a full integrated timeline chronology was compiled and analysed. A narrative chronology was also compiled
- Search all of agency records to identify contacts referring to either DVA, suicide or crime
- Provide an IMR: identifying the facts of their involvement with those identified, 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.
- It was also specifically requested that good practice was highlighted

2.6 Terms of Reference

The purpose of the Domestic Homicide Review is to:

Ensure the review is conducted according to best practice, with effective analysis and conclusions of the information related to the case.

Establish what lessons are to be learned from the case about the way in which local professionals and organisation work individually and together to safeguard and support victims of domestic violence including their dependent children.

Identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on and what is expected to change as a result.

Apply these lessons to service responses including changes to policies and procedures as appropriate; and prevent domestic homicide and improve service responses for all domestic abuse victims and their children through improved intra and inter-agency working.[1]

Specific aims of this review were to:

- summarises concisely the relevant chronology of events including the actions of all the involved agencies;
- analyse and comment on the appropriateness of actions taken;
- make recommendations which, if implemented, will better safeguard people experiencing domestic abuse, particularly those who are older and anyone who may also experience mental health problems or a disability or other chronic ill-health

The review considered the following questions:

- To establish who Ms E's next of kin was and outline her familial and close relationships.
- To establish if family, friends, colleagues, or employer, wanted to participate in the review. If so, to find out a) if they were aware of any abusive behaviour prior to her death and b) if there were indications that Ms E may take her own life

[1] Paragraph 3.3 Home Office Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews

- Whether in relation to family members or colleagues, where there any barriers to reporting suspected abuse. The extent of Ms E's contact with any specialist domestic abuse agency or service in the County. To consider if there were any warning signs which were not acted upon

- Could improvement of the following have led to a different outcome for Ms E;-

a) Communication and information sharing between services.

b) Communication within services.

c) Communication to the general public and non-specialist services about available specialist services related to domestic abuse or violence.

- Whether any organisational policy training or awareness raising requirements are identified to ensure a greater knowledge and understanding of domestic abuse processes and/or services.

- Whether the work undertaken by the services in this case is consistent with each organisation's own:

- Professional Standards

- Domestic Abuse policy, procedure, protocols

- Compliant with its own general protocols, guidelines, policies and procedures

- Whether practices by all agencies was sensitive to the characteristics of the Equality Act 2010, including age, disability, gender reassignment, marriage/civil partnership, pregnancy and maternity, race, sex, sexual orientation, religious belief and specialist needs on behalf of the subjects were properly considered and appropriate actions taken and recorded

- Any other information that becomes relevant during the conduct of the review.

2.7 <u>Parallel Reviews</u>

The Coroner recorded a verdict of Suicide

2.8 Equality & Diversity

There were no equality and diversity issues in this case.

4.0 Key Issues

In summary the key issues to consider were:

- How far and to what extent did the circumstances of Ms E's current relationship and living arrangements contribute to her death in the last two years of her life

- Given that Ms E had 'managed' her substance misuse for 31 years, how far and to what extent were Ms E's current addiction levels a contributing factor

  If it is possible to ascertain if there were significant changes in the last two years? Establish the general state of Ms E's mental and physical health in the weeks prior to her death

- Any other factors that become known during the review

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5.0 Conclusions

5.1 Introduction

In reaching the conclusions in this review focus has been on the following questions:

- Have the agencies involved in the DHR used the opportunity to review their practices, policies and procedures and contacts with the victim and perpetrators to openly identity and address the lessons learnt?

- Will the recommendations in the Review improve the safety of domestic abuse victims in the County in the future?

- Was this death predictable?

- Could this death have been prevented?

5.2 Agencies Review

It can be said that Ms E received appropriate care and support in line with the services that were available at the time. The panel noted the many advances that have been made in the last ten years or so regarding DVA prevention and the services provided.

It is important to say that both Ms E and Mr F fell in and out of engagement often and were adept at deflecting the support offered by agencies. This inconsistency reduced effectiveness of the support offered. There is evidence of good substance misuse management by the GP.

In dealings with agencies there is evidence that agencies readily believed whatever Ms E and Mr F told them. In the early days Ms E did this to prevent Mr F being taken into care. Latterly she agreed to electronic curfews to prevent him serving prison sentences when clearly she did not have the personal capability and resources to deal with him in her home.

Overall there is evidence of good practice and record keeping within agencies. The records of SDAS/Turning Point are an example of good practice, providing both hard data, as well as insightful narrative. Sompar has noted potential improvements to some screens.

CSC say they would have been more proactive had other agencies done more to inform them of circumstances. It is a general observation that when dealing with adult safeguarding issues are under it has tended to be the case that child protection issues are treated as secondary. Today Mr F would be considered a child 'in need' and monitored.

There is past evidence of some multi-agency working but the mechanisms in place today would have ensured more effective coordination to provide both protection and support. For example, had the relationship between Ms E and Mr D become known to agencies today it can be a professional decision to inform about offending history on the grounds of personal safety and risk.

However, although Ms E was able to access a wide range of support no one agency took responsibility for leading and coordinating her support needs consistently as well as ensuring she stayed engaged. It can be seen from the integrated chronology that her engagement with the GP and Turning Point fell away considerably in 2013. Even taking into her account her erratic attendance this was out of character and an agency with an overall lead may have picked this up and explored it further to identify the underlying cause. In the event Ms E did disclose abuse in September.

Apart from the exception of family therapy Mr F and Ms E have been treated separately throughout. Had GP's, Police, the Courts and Turning Point adopted a more coordinated approach to their individual and joint

needs different decisions regarding support and interventions may have been reached. This is particularly true of the last twelve months. It is possible the outcome may have been different.

Throughout this history where the victim must surely be considered as high risk and vulnerable, there were only two recorded signposts to specialist DVA services. There were no referrals. In part this was due to her non-disclosures. It could be argued that agencies, particularly GPs should work from the presumption that an adult in Ms E's position is suffering a degree of DVA and actively promote services even if there is non-disclosure.

In the case of G Ms E's younger son. The intervention of agencies has ensured that he has received appropriate support and is living in a positive environment.

5.3 Was this death predictable or preventable?

A key question In the terms of reference asked the DHR Panel to consider what may have contributed to Ms E's decision to take her own life.

Given that she had managed her drug issues and the challenging lifestyle consequences for over thirty years, what if anything changed in the last two years or so of her life. The following events demonstrate her challenging lifestyle and the context against which she began to disengage with agencies:

1. In 2012 her son who was heavily addicted to illicit substances was expressing suicidal intentions. He was treated as an acute psychiatric admission.
2. In 2013 her son Mr F overdosed. In 2013 her son was electronically curfewed to her home for shoplifting.
3. Ms E is allegedly assaulted by men looking for her son re: drug debts.
4. Her son is again electronically curfewed to her home for possession of bladed article.
5. The next month, the original electronic curfew order is revoked by court and re-set for 5 months (usually 12 hours a day) to her home.
6. Her son smashing up her home because she won't get his drugs.
7. Living in fear of her son due to his heroin and ketamine addiction, causes him to be violent.
8. Living with new partner who has a history of dysfunctional and violent relationships with women. He is a heavy drug user and prolific offender.
9. Son leaves home. She has not seen her youngest son for two weeks. She is unwell and receiving treatment at the GP for an abscess caused by injecting.
10. Daily intakes of Mephadrone, were joined by high consumption of

amphetamine and alcohol.

11. Very volatile relationship with her partner told Turning Point her chest hurt after a fight with him.
12. On the day of her death Ms E had an argument with her partner. She threatened to take pills. He stopped her. She left the home he went to find her and told her to come back, she never returned home. It is not known whether she was in fear of physical violence if she returned to the house.

Given the challenging lifestyle and drug dependence of Ms E it is reasonable to suggest that she would have died a premature death from circumstances arising from her long term drug abuse issues. It is well known that the effects of the drugs themselves, such as infections, and co-dependence on other substances such as alcohol present their own dangers. Long term effects may include deterioration of cognitive and decision making abilities.

In the 12 months prior to her death Ms E had undergone considerable strain. She was the addressee to her son's periods of electronic curfew, one of which was five months long (curfew can be set for up to 12 hours a day). Given the physical and mental health issues he had and the violence he displayed as a result of his drug dependence this prolonged confinement to her address severely impacted on Ms E. Police call outs were made and on one occasion in August she threatened to injure herself by jumping out of a window. She discussed her difficult domestic situation with Turning Point at different visits. This continued from January to August 2013. It can be assumed living in this domestic situation severely drained her emotional resources and impacted on her ability to deal with other situations.

In August Mr D a known violent offender came to live in her home as her partner, she had known him for some time prior. The relationship was known to be turbulent as evidenced by the injuries Ms E discussed at Turning Point in September. On the day she took her own life there had been an argument between them. Mr D said he found Ms E upstairs with pills in both hands which he grabbed from her and threw down the stairs. She left the house at about 10.30pm he found her and asked her to return as it was cold. Ms E didn't return to the house. Mr D responded to a note that Ms E had left for him. The police say that neither of the notes indicated any suicidal intent or any signs of domestic abuse or violence. Although it is not known if she was in fear of physical violence if she returned to the home.

After careful consideration of the evidence available the panel has concluded that Ms E's long history of multi-substance misuse increased the probability of a premature death. When specifically considering suicide the panel recognised that Ms E had 'managed' her drug use and chaotic lifestyle with agency support for many years. She had suffered low moods throughout her life but had rarely expressed suicidal thoughts. Taking all the evidence into consideration it was agreed that suicide was not a predictable outcome for Ms E, although the probability was higher than for

an individual without her problems.

When considering whether or not her suicide was preventable the panel noted that on the day before she died Ms E was undertaking normal tasks such as buying a Halloween outfit for her young son and attending a routine medical appointment. Both activities implied she was making future plans and taking care of her health.

The panel had conversations about the nature of suicide itself and the decision making processes leading to such an action. The panel particularly considered the cognitive abilities of an individual with a very long history of multiple drug and substance misuse. The panel also discussed the impulsivity and risk taking associated with substance abuse. It considered what part this may have played a part in the final decision making moments when she was in distress having the ongoing argument with her partner during which she threatened to take a quantity of pills.

It is possible to conclude that had all the agencies communicated better in the last twelve months of her life and taken steps to support and protect her Ms E's situation may have been less precarious. However, Ms E's disengagement, resistance to interventions and her 'masking' of her true situation was a sufficient enough barrier to prevent the final outcome. Certainly the circumstances and decision making in the final hours of her life were outside of the control of anyone but Ms E herself. Therefore her death was unlikely to be preventable.

The agencies have put forward their recommendations as follows:-

6.0 Recommendations

6.1 **Avon & Somerset Constabulary**

Recommendation 1.
The force procedures and guidance in relation to attendance at attempted suicides is reviewed to ensure all similar calls are recorded appropriately so that Safeguarding concerns are quickly identified and that effective information sharing with relevant support services is enabled.

Recommendation 2.
That all such reports of assault are thoroughly investigated ad all relevant and suspected inured parties are seen in person to ascertain whether any crime has taken place and the extent of any injuries

Recommendation 3
That all attendance for domestic incidents are appropriately recorded for intelligence and Safeguarding purposes allowing effective risk assessments and onward referrals to other agencies including MARAC.

Recommendation 4

That the programme of Domestic Abuse training continues for all Communications staff so that they can recognise and appropriately code and grade reports of domestic abuse incidents.

Recommendation 5

That front-line response officers ensure that in all reports of potential domestic abuse they speak directly, and where possible privately with the suspected victim to establish risk, vulnerability and whether an offence has taken place.

Recommendation 6

That all CID on-call officers are given information and awareness into the DHR process and that they attend al suspected suicides and immediately consider any aspect of domestic abuse as a potential reason for the death. This would require early research of police computer systems and a notification to the HP Policy & Support team who will then coordinate any necessary notification to the relevant local Authority.

6.2 Turning Point

Recommendation 1

A plan has been devised with the key worker to identify what other steps may have been taken and to identify any further training or development needs.

Recommendation 2

To provide mandatory Domestic Violence training for all staff.

To ensure regular updates are cascaded to all staff.

Recommendation 3

Review treatment pathways and re-structure to allow more flexible responses to those identified as having more complex and high risk factors.

6.3 Somerset Partnership

Recommendation 1

To include a prompt via risk screen in core assessments on RIO, the Electronic Patient record (EPR) system, to provide a tick box to indicate

whether the patient is at risk of domestic abuse

Recommendation 2

To provide a link via risk screen in core assessments on RIO, the electronic Patient Record (EPR) system to Multi-agency Risk Assessment Conference (MARAC) information and risk assessment. This would lead to informed advice and guidance from the Trust's MARAC coordinator.

6.4 Children's Social Care Recommendation

All referrals received by the First Response team where children are living in or visiting domestically violent households will be assessed by the Multi-agency safeguarding hub on a daily basis to ensure that the child's experience is captured and proportionate services are provided.

6.5 CCG Recommendation

Recommendation 1.
Information on DVA should be provided to clinical staff and GP practices including awareness of posters, leaflets and resource access routes. Continue this practice

Recommendation 2.
Training should raise awareness of the risk of suicide in vulnerable adults, especially women, who are subject to emotional, physical or psychological abuse, living within or outside of a chaotic drug misuse culture.

Recommendation 3.
Each GP practice should be recommended to have a nominated lead for DVA awareness. Continue this practice.

Recommendation 4.
Practice multidisciplinary meetings should include significant event audits for victims of domestic abuse as a standing agenda item alongside existing items such as Children at Risk and Vulnerable Adults

6.6 Panel Observation

Probation/Courts:

It must be recognised that electronic curfew sentences are onerous on the co-habitants of the offender.

When sentence is passed how do the Courts know that an electronic curfew address is suitable e.g. are vulnerable children or adults living at the address?

The Probation service are not always in court at the point of sentencing to advise. Courts then rely on the word of the offender and/or addressee. No independent enquiries are currently made when one or other persons has a significant history of mental health, drug/alcohol/substance abuse issues to ensure that the addressee has the capability and capacity to withstand the curfew order.

Consideration is given to suitability in DV courts which tend to be better resourced.

This issue should be addressed by the MoJ/HMCTS with a view to issuing guidance or guidelines to sentencers about ensuring the suitability of curfew addresses and hosts, especially when mental health/substance and or alcohol misuse are known to be an issue for either the offender, host or both. This information to be considered by sentencers alongside all the other evidence when determining the appropriate sentence.

This may also be an issue for prisoners electronically curfewed on release.

Glossary

A&E	Accident and Emergency
CAADA	Co-ordinated Action Against Domestic Abuse
CAFTS	Children & adolescent Family Therapy Service
CCG	Clinical Commissioning Group
CID	Criminal Investigation Department
CJU	Criminal Justice Unit
CPS	Crown Prosecution Service
DASH	Domestic Abuse Stalking Harassment and Honour Based Violence
DCI	Detective Chief Inspector Avon & Somerset Constabulary
DHR	Domestic Homicide Review
DI	Detective Inspector Avon & Somerset Constabulary
DVA	Domestic Violence and Abuse
EPR	Electronic Patient Record
GP	General Practitioner
Guardian	Police Live time Crime & Management System
HMICS	Her Majesty's Inspectorate of Constabulary's
IDVA	Independent Domestic Adviser
IMR	Individual Management Review
IRIS	Identification & Referral to Improve Safety
MAPPA	Multi Agency Public Protection Arrangements
MARAC	Multi Agency Risk Assessment Committee
NHS	National Health Service
NSPIS	National Strategy Police Information System
PCC	Avon & Somerset Police & Crime Commissioner
PCSO	Police Community Support Officer
PNC	Police National Computer
PND	Police National Database
PPU	Public Protection Unit Avon & Somerset Constabulary
RIO	Sompar, Electronic Patient Record
SOMPAR	Somerset Partnership NHS Foundation Trust
SSP	Safer Somerset Partnership
STORM	Police Command & Control system

Appendices

Appendix A Action Plan

Appendix B Letter from the Home Office Quality Assurance Panel