Approved by Home Office
November 2015

Safer Somerset Partnership

Feel Safe, Be Safe

Domestic Homicide Review

Executive Summary of the Overview Report

Into the death of Mrs. C
30th November 2013

The Panel sends their condolences
To the family of Mrs. C

B Higgs

Independent Panel Chair and Author

Contents

Please note that the subjects of this report have been anonymised throughout.

1. Introduction

This Domestic Homicide Review (DHR) was commissioned by the Safer Somerset Partnership following the death of Mrs C on the 30th November 2013.

1.1 Case Summary

At approximately 7.50am on Saturday 30th November 2013 the Ambulance Service contacted the police in respect of a call to an address in Somerset.

Mrs C had been pronounced dead by the ambulance team at 07.48. Mrs C. had been found cold and unresponsive in her bed by her husband who had slept on the sofa.

The couple had argued the night before. Mr C disclosed that Mrs C had hit him and threatened to take her own life, as a result he had slept in the living room. He showed police injuries he stated were sustained during that incident.

A half bottle of wine was by the bed and note suggestive of suicide was found at the scene.

The couple had been married for five years during which time the relationship could be described as volatile featuring arguments and injuries. The marriage also featured long absences. Mr C was in the Royal Navy and often at sea. As the marriage difficulties escalated the couple also separated for over a year. Both Mr and Mrs C claim DVA took place in the relationship.

The Post Mortem concluded that death was due to an overdose of prescription anti-depressants and painkillers.

1.2 Background

Originally from the North Wales area Mrs C was 42 at the time of her death. She was brought up by her mother and father, she has a brother.

Mrs C is described as bright, fun and intelligent. She was said to have always had a fiery temper and could hold her own in most situations. However in the latter years was said to be 'troubled' although the reasons why could not be defined. Mrs C had received an on-going GP anti-

depressant prescription from 1997 to the time of her death. Mrs C also had a history of misusing alcohol.

Mrs C met Mr C in November 2007 via an internet site. Mr C was away at sea from January to June 2008 on his return the couple married in August 2008. During the marriage the couple lived in Hampshire, North Wales and Somerset. Both had a history of violence with former partners.

This was Mrs C's second marriage. She has two children by her first marriage and the children remained with their father. This was Mr C's second marriage but third relationship. He has one child by each of his former partners both of whom retained custody of the children.

2.0

2.1 Decision to Conduct a Review

The DHR advisory group decided that there was sufficient complexity in Mrs C'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
Yeovil District Hospital NHS Foundation Trust
Royal Navy
SCC Children's Social Care
Sedgemoor District Council
Somerset Clinical Commissioning Group
Somerset Partnership NHS Foundation Trust
Somerset Safeguarding Adults Board
Somerset County Council Adult Social Care
Taunton & Somerset NHS Foundation Trust (Musgrove Hospital)
Taunton Deane Borough Council
Turning Point/Somerset Drug & Alcohol Service

Victim Support
West Somerset Council

Enquiries were also made in North Wales, Yorkshire and Hampshire

North Wales Constabulary
North Wales (Wrexham) Community Safety Partnership
NHS Wales
Hampshire Constabulary
North Yorkshire Constabulary
Fareham and Gosport Community Safety Partnership

Additional information supplied by:
Welsh Women's Aid Wrexham
Victim Support Hampshire

2.3 Family & Friends

Mr C and Mrs C's mother Mrs T contributed to the review process. Her employer and colleagues were contacted but declined to take part.

2.4 Individual Management Review (IMR)

The following agencies were requested to conduct Individual Management Reviews.

Avon & Somerset Constabulary (host force)
Turning Point/Somerset Drug & Alcohol Service
Somerset Clinical Commissioning Group
NHS Foundation Trust (Yeovil District Hospital)

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

2.5 Purpose of IMR's:

- Provide a chronology of involvement with agencies by Mr. & Mrs. C. From the chronologies provided a full integrated timeline chronology was compiled and analyzed. A narrative chronology was also compiled
- Search all of agency records to identify contacts referring to either DVA, substance abuse, suicidal inclinations or crime
- Provide an IMR: identifying the facts of their involvement with those identified, critically analyzing 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

The overriding purpose of an IMR is to give an as accurate as possible account of what originally transpired within the agency response, to evaluate it fairly, and if necessary to identify any improvements for future practice. The IMR should also propose agency specific solutions which are likely to provide a more effective response to a similar situation in the future.

As the review progressed considerable discussion took place concerning the method that Avon and Somerset Constabulary should adopt to conduct an IMR involving multiple police forces. One school of thought felt that the police should be considered as one agency whereby each force should provide their chronological information to the 'host' force, and that a single IMR should be written to provide information and analysis based on accepted national guidelines for policies and procedures.

A second view was that the 'host' force, in this case Avon and Somerset Constabulary were not best placed to critically assess and comment on the quality or practice of other forces without the knowledge of their individual policies and procedures, and those individual IMRs should be produced by each force. This approach would undoubtedly create resourcing implications for each force to research and analyse all their information and produce an IMR. This would also necessitate either the host force, or the Overview Report author considerable extra work to chronologically order each information to provide an overview of all police interactions with those subject to the DHR.

There were strong arguments for both approaches and in this case, it was agreed that the IMR provided would simply report but not analyse the actions of other police forces.

The DHR Panel members are asked to complete the online DHR training before attending the panel. IMR authors are invited to briefings to assist the understanding of the quality and content required of an IMR. In this case one briefing was offered. Individual agency IMR's should be quality assured by the DHR panel member before being forwarded to the Independent Chair of the Panel. The IMR must be signed off by a responsible officer in the organisation who will also maintain the strategic ownership of the individual agency action plan.

The preliminary information known to the first DHR meeting included the following:

- Mr and Mrs C both had children from previous relationships.
- Both Mr and Mrs C had assaulted each other during the course of the relationship. That Mr C verbally abused Mrs C.
- That Mrs C had a history of 'low mood' and a long history of

prescribed anti-depressant medication.

- That Mrs C had a history of alcohol misuse.

There were considerable gaps in knowledge at the outset partly due to the fact that the couple had lived in three areas, North Wales, Hampshire and Somerset. It was agreed that the Terms of Reference would include the involvement of these areas to complete the background and agency involvement that the couple experienced.

To review events for a minimum of 6 years preceding the domestic abuse related death of Mrs C on 30th November 2013, unless it became apparent that the timescale in relation to some aspect of the review should be extended.

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

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

The review considered the following questions:

- To establish a profile of Mrs C and her family 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 Mrs C may take her own life

- Whether in relation to family members or colleagues, where there any barriers to reporting suspected abuse. The extent of Mrs C'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 Mrs C;-

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 Parallel Reviews:

Coroner

2.8 Equality & Diversity

There were no equality and diversity issues in this case.

3.0 Key Issues

- How far and to what extent did the circumstances of Mrs C's marital relationship and living arrangements contribute to her death
- How far and to what extent did the circumstances of Mrs C's family life contribute to her general well-being
- To establish what if any specialist DVA support was offered to either Mr or Mrs C
- Whether the fact that Mr C was military personnel had any bearing on the accessibility to specialist services
- Any other factors that become known during the review

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4.0 Agency Reviews

Avon & Somerset Constabulary IMR Analysis

On the day of death the correct staff was deployed and the initial consultation between attending officers and line managers took place in line with the Avon & Somerset Constabulary domestic abuse policy.

The case presented as a suicide but the PM identified areas of concern and a forensic PM was arranged without loss of evidence.

Once deeper research was conducted the family domestic history became evident.

Lessons Learned

The response in the case was proportionate given the information available at the time. However, the officers were unaware of information held by the

Ministry of Defence, Hampshire Police, Yorkshire police and Welsh police about the individual's history and history as a couple.

Ministry of Defence/Armed Services

The Panel discussed the issue of liaison between the MoD with regard to

- Policing
- Health – primary care level
- Alcohol and Drug Services
- Safeguarding Adults and Children

Liaison between the armed services and the equivalent civilian services for intelligence-sharing and cooperation purposes seems to be uncovered by an approved protocol.

It was also not known by the panel what level of expertise exists in the Armed Services regarding domestic abuse and violence, drug and alcohol support. It was also unclear what level of support is offered to the partners of military personnel. This arises in respect of MoD taking no action against Mr C in respect of DVA assault when informed by North Wales police and on another occasion asking Mrs C to leave married quarters when there was a joint assault.

Panel members were also aware that victims of domestic violence whose spouse was in the military had a significant barrier to reporting as they did not want their spouse to get into trouble at work or lose military quarters.

In Somerset RNAS Yeovilton is a significant presence. Somerset County Council led services endeavour to establish and maintain links at an operational level. However, these links are not formalised and perhaps should be particularly with regard to MARAC and MAPPA work. This is an issue that should be considered nationally.

The Armed Services also do not appear on the statutory list of agencies/organisations required to take part in DHR reviews. This should be reviewed with a view to requiring their participation when military personnel are involved.

Turning Point Analysis Somerset Drug and Alcohol Service IMR Analysis

At the time of Mrs C's death the service had rigid treatment pathways that did not always allow for flexibility. Mrs C was offered support within the service guidelines at the time. A review of the service in February 2014 and a restructuring of the service as a whole now allows for a more flexible approach to need. Referrals are no longer closed if the audit questionnaires are not returned and a more robust follow up process will try

to engage the client.

The service has recognised that less experienced staff may not be equipped with the skills to carry out in depth discussions with a client around the issues of DVA and what actions are necessary. There is now mandatory training in DVA and all staff has information available as to what actions to take including a greater awareness of their ability to make a professional referral to MARAC and other support services. All staff has the opportunity to attend MARAC as part of this process.

Somerset Clinical Commissioning Group (GP) IMR Analysis

It is of concern that when individuals are with the armed forces and able to access health services from the medical officer that they are seen and assessed only for that consultation without full assessment of risk for the wider family unit. The services medical record is limited which then in part provides a medical history for the primary care GP surgery to inform subsequent consultations and decision making when seen in consultation following reports of violence. This is particularly pertinent if both armed medical services and primary care services are being used to ensure that a seamless current medical record is maintained. It is unclear from the historical records about the whereabouts of either partner's children from previous relationships.

Just before Christmas 2008 Mrs C presented to her GP with two black eyes, apparently from a fall landing onto her face. The record does not contextualise this incident.

GP Surgery

Mrs C was generally seen by her own (female) GP. Medication for anti-depressants as previously detailed. The GP followed good practice when asking Mrs C specifically about domestic violence and whether or not she felt safe. Following the domestic incident in 2011 and her assurance that she felt safe there was no further disclosure or reported incident of violence of any kind against her, or her husband. The issue of alcohol dependence was not mentioned to the GP and there was a reluctance to share why she had left her children and unclear whether she was seeing them

The GP surgery was aware of the hospital admission but minimal details were received.

Lessons Learned

It is unclear from the consultations before Mrs C registered with the recent surgery that there was any consideration as to the potential risks presented pertaining to DVA and if the children from her previous relationship were affected. It is paramount that the safety of children should be considered if and when there is any reported violence.

It is good practice for surgeries to review and produce a summary of

previous medical attendance and significant problems to inform future consultations and not rely on the patient providing the history. This practice has been emphasised to staff recently.

It is good practice that the GP specifically sought clarity on registration whether there was any current concern or history of DVA given the historical information recorded and detailed by the patient.

This GP surgery has a DVA lead who was also Mrs C's GP. This GP attends annual safeguarding training which includes domestic abuse and is aware of the local services for referral. She provides updates to the practice staff, particularly GPs and nurses. The GP is aware of CAADA. The last training was in February 2014.

Since the death of Mrs C a significant event review has been conducted. Learning has included a review of having difficult conversations.

Yeovil District Hospital NHS Foundation Trust – IMR Analysis

The Trust's involvement with Mrs C was reviewed. The emergency department does not use a formal depression score and in the absence of any self-harm there was no reason to use the risk matrix. Assessments made by the medical staff were as expected for a patient presenting in her circumstances.

The referral to the Alcohol Liaison Team is written and these are taken from the emergency department on a daily basis. Mrs C agreed with the referral but emphasised her husband must not be told

There was no evidence of gaps in knowledge or of inappropriate resources being deployed. There were no delays in procedure or delivery of service. However a referral to a DVA service was not made.

There was evidence of good practice in terms of full assessments and identification of issues at the time of Mrs C's Emergency Department attendance. Referrals were appropriate and documentation completed.

A hospital discharge notice was sent to the GP but did not contain notification of the DVA or the referral to Turning Point. Therefore denying the GP the opportunity to contact the patient for a follow up.

5.0 Findings

The terms of reference required this report to

- To establish a profile of Mrs C and her family 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 Mrs C may take her own life

- Whether in relation to family members or colleagues, where there any barriers to reporting suspected abuse. The extent of Mrs C'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

These objectives have been achieved and a summary of key points follows:

Mrs C had a relatively stable and supportive family background in North Wales.

From her first marriage she had two children who remained with their father after an amicable divorce.

Mrs C had a 15 year history of anti-depressant medication. As a result of an arm injury Mrs C also took large quantities of strong pain killers. She was also known to have a long history of misusing alcohol and this was known to have seriously escalated in the seven weeks or so prior to her death. Misuse of alcohol would have reduced the effectiveness of anti-depressant medication.

Mrs C was the victim of serious assaults during her life. First at her work with NACRO, second at the hands of her partner in Yorkshire in 2007, third in the attack by youths in 2008.

The evidence from agencies shows that the marriage to Mr C was a volatile relationship featuring alcohol, arguments and violence by both parties. Mr C's account that he was solely the innocent victim of her violence is not credible as Mrs C often evidenced significant injuries that went beyond those that would have been caused by self-defence. Mrs C sought medical attention for injuries in 2008, 2010, after violent incidents. After another incident in 2009 Mrs C left to return to Wales.

However, Mrs C did have a strong personality and it is known she became violent when in drink. In 2007 she was cautioned for stabbing her then partner in York. Mr C claims that she assaulted him often and on one occasion threatened him with a knife. She also assaulted her mother in full view of her daughter.

After the incident of assault on her mother she left her family in Wales and had no further contact with them. She left to reconcile with Mr C. Mrs C's mother knew the relationship was tempestuous and suspected there was violence in the relationship and tried to help her daughter but her attempts failed. She said she didn't trust Mr C and that he manipulated and controlled her daughter.

Mrs C's use of anti-depressants continued, her use of alcohol escalated.

In terms of barriers to discussing DVA, Mrs C took opportunities to report DVA to specialist agencies and her GP in Wales and did so on numerous occasions. She received good support and assistance in North Wales.

However, she was more reticent in Somerset discussing one historical incident of DVA with her GP and nothing about alcohol. She disclosed DVA information to the hospital/turning point six weeks prior to her death but this information was not passed to her GP by the hospital/turning point nor was she referred to a specialist DVA organisation. This was an omission and a missed opportunity for effective intra-agency working.

There is no evidence that Mr C either sought or received relationship support. He had attended Relate concerning his previous relationship and counselling in respect of the 2008 assault so would have been aware of the availability of this type of assistance with relationship issues.

However, Mrs C did not always take up referrals nor make full disclosures to her GP so it cannot be said that this would have necessarily changed the outcome.

Mrs C had a subsequent visit to the GP ten days prior to her death but chose not to disclose DVA or alcohol misuse on that occasion.

6.0 Conclusions

Predictable?

In deciding whether or not Mrs C's death was predictable it can be evidenced that prior to her death Mrs C was living under a number of significant stresses which may have had more or less impact on her general well-being and mental health:

- Mrs. C was isolated from her family. Her family says that she had 'burnt her bridges' with them. The relationship with her family had broken down following the assault on her mother. Mrs. C may have felt she had no option but to return to her husband but she had told her mother that she still loved Mr. C. She was dependent on the relationship for the last 22 months of her life and may have felt trapped in a failing and violent marital relationship.

- Mrs C was estranged from her children. It can be speculated that the arguments with Mr C about access to his children and relationships with former partners may have arisen out of jealousy and/or her feelings as regards missing her own children.

- The cumulative effective of years of prescription drugs and taking high dosages of over the counter pain killers combined with the misuse of alcohol and a continuously turbulent relationship will all have played a significant role.

- Mrs C was known to have been a bright woman but her criminal record and the restricted ability to travel due to her drink drive disqualification meant she was unable to access the type of work of which she was capable. She worked on the production line in a local factory which was well below her intellectual capabilities, she reported it was stressing her and she was looking for other work.

Mrs C's mood and behaviour dramatically worsened in the last 7 weeks of her life. She pinpoints this to a paternity issue over Mr C's daughter although he denies this was ever an issue. It is more likely that all of the above factors overwhelmed her. This was heightened prior to the day of her death by an argument that had gone on all day with her husband via phone and text and culminated in a physical fight between them that evening where both sustained minor injuries.

7.0 Recommendations - Scope is Local unless otherwise stated

Preventable?

Throughout the period of the terms of reference Mrs C accessed specialist help and disclosed DVA to the police, health professionals and specialists North Wales. There records indicate the help and support she received was appropriate, of a good standard and in line with the processes, policies and procedures in place at the time.

In Somerset Mrs C did not seek help for her drinking and or disclose DVA to her GP. Once her level of drinking and DVA was disclosed to the hospital an appropriate referral was made to the alcohol liaison worker and she was seen the same day. Turning Point worked in a timely way and within the procedures operating at the time. Mrs C failed to respond to later correspondence sent to her. However the DVA disclosure was not acted upon.

There were no barriers Mrs C accessing either general or specialist help. She was specifically asked by professionals on two occasions in the last two months of her life if she was suffering verbal or physical violence. To her GP she expressed that she felt safe but to the hospital disclosed verbal and physical abuse. On a subsequent visit to the GP 10 days before her death Mrs C did not mention DVA or drinking.

The hospital records show patient disclosure information concerning DVA and serious alcohol dependency yet this was not shared with the GP. This can be considered a missed opportunity to practice effective multi-agency working. Mrs C's GP is the DVA lead for the practice and would have been able to broach the matter with her if aware.

However, it is also true that Mrs C did not take up the appointment made at Turning Point so it is equally possible that she would not have taken up a DVA referral had one been made.

Finally, there is also evidence that Mrs C's own impulsive nature was exacerbated by alcohol misuse. Impulsivity is a known characteristic of substance misuse in which individuals do not always consider their actions in light of the consequences. This can lead to high risk behaviour with outcomes that are not always intentional.

Therefore it is possible to conclude that in all the circumstances that with the information known at the time that any actions that either were or could have been taken by the agencies would have been unlikely to have prevented this death.

7.0 Recommendations - Scope is Local unless otherwise stated

Please see action plan (appendix A)

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 Violence 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 (TBA)