A Domestic Homicide Review into the Death of Adult A

EXECUTIVE SUMMARY

A report for the Safer Cornwall Partnership

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Introduction

1. At 1037 hours on the 13th May 2012 Ambulance Services were called to *(Redacted)* in the small village of *(Redacted)* near *(Redacted)* and found Adult A unconscious with a wound in his chest and a pair of scissors lying next to him. Adult A was airlifted to *(Redacted)* but efforts to resuscitate him failed and he was pronounced dead at 1147 hours on Sunday 13th May 2012. His wife, Adult B admitted throwing the scissors during an argument and was convicted of manslaughter due to diminished responsibility on the 8th November 2012. Adult B was sentenced to 9 years in prison.

2. Adult A and Adult B were married and living in the same household at the time of the homicide. Safer Cornwall concluded that the death of Adult A met the criteria for a DHR and commissioned a review in line with the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2011) with the purpose of:

   - Establishing what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations worked or work, individually and together to safeguard victims;

   - Identifying 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;

   - Applying these lessons to service responses including changes to policies and procedures as appropriate; and

   - Identifying what needs to change in order to reduce the risk of such tragedies happening in the future

   - Improving service responses for all domestic abuse victims and their children through improved intra and inter-agency working.

3. The timescale for this Domestic Homicide Review Panel was unusual in its duration in that the criminal justice investigation exposed a history of violent behaviour relating back to Adult B's childhood and continuing through her adult life. Presented with this evidence, the Domestic Homicide Review Panel extended the scope of the review for Adult B from the **1st January 1963** up to the date of the death of Adult A on the **13th May 2012.**

4. No information (relevant to the Terms of Reference) was held on Adult A by any agency prior to the couple's move to Cornwall in 2004, therefore the Panel decided to review agency contact with Adult A from the **1st January 2004** up to the date of his death on the **13th May 2012**.

5. A Panel of Professional Advisers was appointed to assist the Independent Chair in reviewing the lessons learnt from this homicide. Panel members were selected based on their independence, having had no previous connection or tie to the family or any responsibility for direct line management of any member of staff involved with the case over the past 5 years.

6. The Panel were committed to the ethos of equality, openness, and transparency. There was no suspicion of concealment and all factors were thoroughly considered with an objective, open-minded, impartial and independent view.

7. The Review Panel secured records and reviewed contact with 26 agencies and invited four organisations to undertake a full Individual Management Review (IMR) under Section 9 of the Domestic Violence, Crime and Victims Act 2004;

    a. Bedfordshire Police

    b. Luton Children's Services

    c. Cornwall and Isles of Scilly Primary Care Trust[1]

    d. Cornwall Education Department

[1] In relation to G.P records

8. Twelve Professionals were interviewed from three different organisations. Unfortunately individuals employed during the period of social services involvement (1985-2001) were no longer in post.

9. The Independent Chair invited Adult B and family members of Adult A to participate in the review. Each family member considered the invitation but declined to participate initially. Adult A and Adult B worked for the same company leading up to the homicide. Their employer also declined to participate in the review although the Head of Human Resources at the company head office expressly asked to be informed of the outcome of the Domestic Homicide Review and any recommendations for the company that will help improve the welfare of its employees.

10. It should be noted that in the absence of the views of family, friends and co-workers, the Review Panel has referred to testimonies obtained from witness statements provided to the criminal justice investigation.

11. The views and conclusions contained within the overview report are based on findings from both documentary evidence and some interview testimony and have been formed to the best of the Review Panel's knowledge and belief.

12. The Panel would like to express their sincere condolences to the family and friends of Adult A and thank the professionals, agencies and IMR Authors who dedicated their time, commitment and tenacious attention to detail throughout the Domestic Homicide Review.

Terms of Reference

13. The following areas are addressed within the Individual Management Reviews and the Overview Report;

- Establish whether the incident in which Adult A died was a 'one off' or whether there were any warning signs that would indicate that more could be done in Cornwall or Bedfordshire to raise awareness of domestic abuse.

- Establish whether family, friends, neighbours and work colleagues were aware of any abusive or concerning behaviour from the perpetrator to the victim (or other persons), prior to the homicide.

- Establish whether there were any barriers experienced by the family/ friends/colleagues in reporting any abuse or concerns in Cornwall, Bedfordshire or elsewhere, including whether they (or the victim) knew how to report domestic abuse had they wanted to.

- Identify whether there were opportunities for professionals to enquire or raise concerns about domestic abuse in the household.

- Establish whether the perpetrator had any previous concerning conduct or a history of abusive behaviour and whether this was known to any agencies.

- Identify whether there were opportunities for agency intervention in relation to the perpetrator (e.g. aggression, mental health issues or child protection arrangements) that were missed.

- Identify any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and / or services in the county.

- Give appropriate consideration to any equality and diversity issues that appear pertinent to the victim, perpetrator or family members e.g. age,

disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

- Consider any other information that is found to be relevant.

Brief Synopsis of Case

14. At 1037 hours on the 13th May 2012 Ambulance Services were call to *(Redacted)* in the small village of *(Redacted)* near *(Redacted)* and found Adult A unconscious with a wound in his chest and a pair of scissors lying next to him.

15. Adult B was hysterical and had been the original caller to the Ambulance Service. She admitted throwing the weapon, a pair of dress making scissors, at her husband during an argument about cleaning the house.

16. Adult A was airlifted to *(Redacted)* but efforts to resuscitate him failed and he was pronounced dead at 1147 hours on Sunday 13th May 2012.

17. Adult A was 48 years old at the time of the homicide. He was fondly remembered by friends, neighbours and colleagues as a private man, polite and friendly, laid back and a thoroughly nice person.

18. Adult A met Adult B in 2001 in Luton. He sold his house and moved into Adult B's council accommodation in 2004. Adult A and Adult B later moved out of their Council accommodation into private rented accommodation and subsequently moved two or three times more within Luton before moving to Cornwall (also in 2004). They married in 2009.

19. Adult B was married three times before marrying Adult A. She had four children from separate marriages and a fifth child from a more casual relationship. Adult B did not have any children with Adult A (her fourth husband).

20. Adult B was born in 1963 and was the eldest of three children. She was placed into care at the age of 14 due to her violent temper and her mother's fears for her

two younger siblings. Her mother expressed concerns that Adult B *"would end up murdering someone"*[2].

21. The first recorded agency contact with Adult B dates back to 1975 when she was just 11 years old. Between the ages of 11 and 15 there are 14 recorded contacts between Adult B and her G.P for violent and destructive behaviour requiring medication.

22. Between 1995 and 2004 there are 18 recorded contacts with Bedfordshire Police. The majority of these contacts relate to concerns for the welfare of Adult B's children and latterly, missing persons reports for Adult B's fourth child (C4).

23. There were eleven known or recorded occasions during the period 1985 to 2002 in which Luton Children's Services were informed of the children alleging to be, or reported by Professionals to have received, a non-accidental injury from Adult B. These concerns include an attempted strangulation of her third son (C3) and knocking out the tooth of her second son (C2). All contacts relating to Adult B and her five children are recorded within two case files, held by Luton and Bedfordshire Children's Services, and contain a total of one hundred and seventy nine (179) items.

24. Adult B sought help from her G.P on approximately 25 occasions for violent outbursts and severe mood swings throughout her adult life. She attributed much of her behaviour to severe PMT however this was discounted when her mood swings intensified after a full hysterectomy in 2006.

25. Two of Adult B's ex-husbands (H1 and H2) provided statements to the Police describing Adult B as *'violent and unpredictable'*. Both husbands reported previous knife attacks, one of which resulted in a severed artery in his leg. Each of Adult B's five children described an upbringing where they were *'emotionally and physically abused with numerous relationships, addresses and schools'.*

26. Adult B's violence was witnessed by a minimum of 11 family members, neighbours and work colleagues between 2001 and 2012. They appear to be the only individuals aware of, and witness to, domestic abuse between Adult A and

[2] A letter from the Education Welfare Officer to the GP on the 17th March 1978

Adult B. Incidents included a *'frenzied assault'* witnessed by a work colleague and a *'glass bottle attack'* witnessed by a neighbour. Three of Adult B's children witnessed her regularly *'punch, slap, scratch and throw things at (Adult A').*

27. Adult B did not deny her violence towards Adult A during the criminal investigation or Domestic Homicide Review. She said that her relationship with Adult A had its *"ups and downs".* During the down times she said, *"We would argue daily and I would often end up throwing anything and everything at him.…He wasn't like anyone I ever met before, he was different. He was chilled, so relaxed…He would generally walk away from me when I threw things, I would follow or try and call. I went through so many mobile phones by throwing them at the wall…It was annoying when he wouldn't argue back".*

28. Adult B informed the Independent Chair that the argument leading up to the homicide was not any different to any other argument she had with Adult A. She said *"I was just throwing stuff…next thing, he was next to me, I caught him; that was it…*"

General Conclusions

29. The scope of this Domestic Homicide Review spanned over four decades and specific lessons were identified for each individual agency involved with Adult A, Adult B and her family. Agency conclusions and lessons learnt are recorded within the full Overview Report; which will be published in full on the Safer Cornwall Partnership website. General conclusions from the DHR are highlighted below;

30. With the presenting evidence of a history of violent outbursts, throwing random items in violent rages and Adult B's previous use of weapons against ex-partners, the Panel would conclude that Adult A's death was not a 'one off' in so far as 'luck' played a part in averting the death of others. In particular, the fatality of H2 was prevented in 1989 by immediate life-saving medical intervention to stem the

loss of blood caused by a severed artery.

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31. The only witnesses to domestic abuse against Adult A between 2001 and 2012 were Adult B's children, neighbours and work colleagues. The Panel cannot speculate on why individuals did not report the incidents of abuse to authorities; however it is a possibility that the violence or threat to life was not overt when incidents were considered in isolation of each other. It was only when the cumulative incidents were pieced together that a picture emerged of sustained emotional and physical abuse.

32. Traditional gender stereotyping also played a significant role in this case. It is feasible that the violent behaviour of Adult B was never associated with domestic abuse because the conventional perception is that intimate terrorism (or one-way violence involving power and control) is almost entirely perpetrated by men.[3]

33. There is evidence that Adult A was ridiculed in the workplace and community with colleagues and neighbours mistaking his passive resistance to Adult B's violence as a critic of his masculinity. Conversely Adult B's behaviour was often given the benefit of the doubt or attributed to pre-menstrual tension. The combination of not taking male abuse seriously and not holding Adult B to account for her behaviour were important factors in the outcome of this case.

34. The co-occurrence of child abuse and adult domestic violence and the psychological, behavioural and emotional effects that living with domestic abuse would have had on Adult B's children was certainly a missed opportunity to protect them by Children's Services, Education and Health Professionals between 1980 and 2004.

35. Adult B's long history of violence was well documented within records retained by statutory agencies; however this did not translate to Adult B's history of aggression *'being known'*. The information was undoubtedly available but

[3] Johnson 2006 - A Typology of Domestic Violence: Intimate Terrorism, Violent Resistance, and Situational Couple Violence (Northeastern University Press, 2008)

individual Professionals did not always 'make the link' with historic records and/or understand the dynamics of abusive behaviour. There appears to have been a culture of responding to the present concern rather than the accumulative history of intelligence. This 'blinkered' approach by agencies in the early days of Adult B's offending, prevented Professionals from understanding and assessing the collective risk of her violence towards her children and partners.

36. Communication between agencies was hindered further by Adult B's frequent change of home and name. The Review Panel conservatively estimates that Adult B and her children moved home between twelve to twenty occasions during 1985-2002 (which could be perceived as an attempt to avoid detection). Each move often involved a change of school and G.P Surgery. The constant moving of address was identified as a barrier to information sharing between agencies as important information (including up-to-date contact details) were often lost within an ever-expanding volume of medical and social care records. Local agencies were also unable to link Adult B's previous violent history with new presenting issues.

37. Various agencies were involved or had contact with Adult B throughout her life from Education Welfare Officers, Social Workers and Consultant Psychiatrists to Police Officers, Teachers and General Practitioners. Although child protection concerns were identified on many occasions by multiple independent Professionals, no risk assessment was ever undertaken during any period of the review and the children were never discussed at a child protection case conference.

38. The Review Panel identified through this DHR, that Professionals were not confident and knowledgeable about how and when to share information, proportionately, appropriately, legally and ethically, in the interest of public protection and for the prevention of crime and disorder. This is an area that still has a significant and detrimental impact on the effectiveness of sharing information and intelligence between agencies and must be addressed to assist

in the management and tracking of dangerous, serial perpetrators.

39. During the course of the Domestic Homicide Review, the Panel became aware of a lack of knowledge of the DASH (2009) Risk Assessment Checklist. This was found across the board of non-police agencies (not including specialist domestic abuse services) and validated concerns that Professionals responsible for the safeguarding of children and young people, vulnerable adults and adults at risk (as defined by No Secrets DH 2000) perpetrators and the general public do not have a cohesive understanding of risk in order to identify domestic abuse and *activate* the commissioned domestic abuse pathway/response.

OVERALL RECOMMENDATIONS [4]

This Domestic Homicide Review has identified a number of recommendations for local, regional and national practice. For ease of reading, the recommendations have been separated into the following headings;

- Cornwall Recommendations
- Cornwall & Bedfordshire Recommendations
- Bedfordshire & Luton Recommendations
- National Recommendations

CORNWALL RECOMMENDATIONS (1-6)

RECOMMENDATION 1: Following four consecutive Domestic Homicide Reviews involving male victims in Cornwall in 2012/13, the Safer Cornwall Partnership should seek to understand if this recurrence of male victims is an unfortunate happenchance or a 'chink in the chain' of support for males. In response to the sequence of unrelated DHRs, the Safer Cornwall Partnership will need to raise

[4] Recommendations are linked to actions (to achieve the recommendations) – See SMART Action Plan

public and professional awareness of male victimisation[5] and seek to dispel gender assumptions by focusing on the context of violence within relationships.

RECOMMENDATION 2: The Review Panel recommends that the Safer Cornwall Partnership commissions academic research to better understand how existing theories such as Professor Michael P. Johnson's Typologies of Domestic Abuse[6], and the Duluth Domestic Violence Model[7] impacts on service design and efficiency of support in Cornwall, including the appropriateness of our partnership, community and criminal justice response to the different forms of abuse.

RECOMMENDATION 3: This Domestic Homicide Review has identified that victims of Domestic Abuse in Cornwall are still reluctant to TELL; Professionals are still reluctant to ASK, and too many Practitioners do not possess the knowledge to IDENTIFY signs of abuse, ASSESS the level of risk and REFER to the Domestic Abuse Pathway.

The Independent Chair recommends that the Safer Cornwall Partnership develops a culture that encourages individuals to TELL, ASK and REFER.

This should be achieved through the commissioning of a Multi-Agency DASH Risk Assessment Training Programme that is linked to the launch of REACH[8] and the communication strategy to increase public awareness of Domestic Abuse (See Action 3).

RECOMMENDATION 4: The Panel recommends a phased strategy (2014 – 2015) by the Safer Cornwall Partnership to encourage, promote and assist public and private sector organisations to introduce specific domestic abuse policies for

[5] Male victims are not a homogenous group and include victims of heterosexual , LGBT and intra- familial abuse

[6] A Typology of Domestic Violence: Intimate Terrorism, Violent Resistance, and Situational Couple Violence (Northeastern University Press, 2008)

[7] http://www.theduluthmodel.org/

[8] REACH is a multi-agency HUB developed to provide a single gateway for Risk Assessment, Evaluation and Coordination of Help for Domestic Abuse. The HUB is due to open in Truro on the 1st March 2014 and will implement a phased launch to Professionals and the Public. It will facilitate *'the right support at the right time'* accordingly to the level of risk.

employers/employees in the workplace. This could be achieved by linking into Cornwall Council's Healthy Workplace Award Scheme.

RECOMMENDATION 5: The Review Panel recommend that aspects of this report which relate to the omission of the history of violent attacks and domestic violence from the medical case note summary of Adult B should be shared with the note summarisers and clinicians at *(Redacted)* Surgery in order to emphasise the importance of this work and the lessons learnt from this DHR.

RECOMMENDATION 6: The Panel does not know if the medical case notes of Adult B have been appropriately summarised for future clinicians. When Adult B is released from Prison in 2017 her care will transfer from the prison authority to the General Practitioner in the area of her residence. To ensure Professionals are fully informed on the risk that Adult B poses, the Panel recommend that the Probation Service facilitate communication with Prison Services and MAPPA to ensure Adult B's medical records are appropriately summarised to include a record of her previous behaviour leading up to the homicide. MAPPA will need to ensure that this information is considered as part of her risk management plan.

CORNWALL & BEDFORDSHIRE RECOMMENDATIONS (7-9)

RECOMMENDATION 7: Education staff in Cornwall and Bedfordshire responsible for the administration and supervision of school transfer records should be made aware of the lessons from this DHR and reminded of the importance of using school2school[9] for the secure transfer of pupil information (for families who frequently move between local authority areas) in line with the Department For Education's 'Children Missing Education' Statutory Guidance for Local Authorities (2013).[10]

RECOMMENDATION 8: This Domestic Homicide Review has identified an immediate recommendation to review how information from Strategy Group

[9] http://www.education.gov.uk/researchandstatistics/datatdatam/s2s/a0064650/school-to-school-s2s
[10] Department for Education - 'Children Missing Education' Statutory Guidance for Local Authorities (2013) p8.

Meetings can be disseminated to first response and investigation officers within Bedfordshire Police and Devon and Cornwall Police to ensure officers have *all* available information to inform the appropriate response to individuals.

In addition, Devon and Cornwall Police should explore the feasibility of 'flagging' repeat Domestic Abuse victims, perpetrators and missing persons on the Unify System. Devon and Cornwall Police to feed back to the Sexual Violence Domestic Abuse Strategic Group.

RECOMMENDATION 9: All Police Officers and Staff within Bedfordshire Police and Devon and Cornwall Police need to be reminded immediately of the requirement to submit a form 745 Child at Risk Report (or 121a for Devon and Cornwall Police) following any event involving a vulnerable child or where there is concern for a child's welfare.

Officers within Devon and Cornwall Police should be reminded that a separate safeguarding alert must to be raised **in addition** to a 121a where there is a significant concern of risk for a child living in a domestic abuse household. Officers should consistently use existing, formal procedures for referral to the Multi Agency Referral Unit (MARU).

BEDFORDSHIRE & LUTON RECOMMENDATIONS (10 – 11)

RECOMMENDATION 10: The Children's Service Records pertaining to Adult B's children C1, C2, C3, C4 and C5 should be revisited and organised in chronological order to ensure that records are decipherable and accessible should any dependent of Adult B chose to request access to personal information.

RECOMMENDATION 11: The Panel recommends that Bedfordshire and Luton Children's Services undertake an audit of the current Safeguarding training for Social Workers to ensure that the course contains a domestic abuse specific module to equip Practitioners with the knowledge to make informed decisions about the care and level of intervention for children living in domestic abuse households.

Specifically, the Panel recommends that ACPO DASH Training is included, or offered in addition to, Child Safeguarding Courses.

NATIONAL RECOMMENDATIONS (12-17)

RECOMMENDATION 12: Early Intervention is pivotal in recognising domestic abuse before it becomes high risk. It is inconceivable to think that Domestic Abuse Training is not considered a mandatory component within University or College Courses for Community Development, Public Sector, Criminal Justice, Social Care or Healthcare Professions.

The Review Panel recommends that the Government works with the UK Commission for Employment and Skills to explore the inclusion of Domestic Abuse Risk Assessment Training within National Occupational Standards for Professions that routinely respond to Domestic Abuse, Stalking, Honour Based Violence, Child Abuse, Sexual Abuse and Animal Abuse.

RECOMMENDATION 13: NHS England should review the non-attendance policy for appointments to ensure that G.P's are clear on their obligation and accountability to follow-up referrals made to specialist services/treatment, especially where non-attendance could have a significant impact on the safety of patients or others.

Commissioners should review non-attendance policies and feedback to Contract Management.

RECOMMENDATION 14: The Review Panel recommends a review of the Firearms Licence Application Process to ensure that all individuals in a household are vetted in addition to the named applicant.

RECOMMENDATION 15: Adult B's violent history was not highlighted in case note

summaries produced by several G.P surgeries prior to, and during, Adult B's relocation to Cornwall. This could be evidence of a systemic problem in the process of case note summarising which might place health Professionals and other patients at risk of harm. Healthcare Professionals need to have an awareness of the level of risk when presented with someone with a history of violence

The Panel recommends that NHS England carry out a review of the current system for case note summarising to ensure that it is safe and fit for purpose.

RECOMMENDATION 16: Adult B disclosed her violent outbursts towards other family members, to a number of G.P's during her adult life. Despite the whole family being registered at the same surgery, there is no evidence of a G.P making a routine enquiry about the welfare of the said family member(s). The Panel was informed that this was not feasible because the national electronic care record does not have the capability to enable surgeries to link family members (with different or same surnames).

The Panel recommends that NHS England investigates the attainability of upgrading the national electronic care record to include the facility of linking family members and coding dangerous domestic abuse perpetrators.

RECOMMENDATION 17: The DHR Panel would like to see domestic abuse recognised within Primary Care for G.P's through the addition of a National QOF Indicator for routine enquiry and the maintenance of a domestic abuse register (similar to a register for patients with hypertension or diabetes).

NOTE: *The Safer Cornwall Partnership has no jurisdiction over the Government, NHS England or any other Local Authority outside of Cornwall and the Isles of Scilly. Although recommendations have been suggested for Bedfordshire, Luton, NHS England and Central Government, the Safer Cornwall Partnership cannot enforce their application. It is for individual agencies/political parties to decide whether to accept and action specific recommendations in order to learn lessons and prevent further tragedies.*