Norfolk County Community Safety Partnership

DOMESTIC VIOLENCE HOMICIDE REVIEW

EXECUTIVE SUMMARY

REPORT INTO THE DEATH OF:

Mrs A age 44 years

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1 The Review Process:

1.1 This summary outlines the process undertaken by the Norfolk Community Safety Partnership domestic homicide review panel in reviewing the death of Mrs A.

1.2 From the Police investigation there was evidence that the homicide was committed by Mrs A's husband Mr B. Mrs A was killed when she was shot at close range with a shotgun. There were no criminal proceedings as Mr B committed suicide with the same shotgun after taking Mrs A's life. At the Coroner's Inquest on 24 September 2013 a finding was made that Mr B killed Mrs A unlawfully and that he then committed suicide. The Coroner commented that the killing appeared to be deliberate and Mr B had made the decision to kill himself and he had made plans to undertake this. The act was not due to a sudden loss of control

1.3 The Review process began with a meeting called by the Chair of the Norfolk Community Safety Partnership 12 days after the fatal incident and the decision was taken that the circumstances of the case met the requirements to undertake a Domestic Homicide Review. The Home Office was then notified of this decision as required by statute. The Review was concluded on 21 June 2013. This is slightly over the statutory guidance to complete a Review. The deliberations of the Panel were confidential until the Review was approved for publication by the Home Office Quality Assurance Panel. Approval was granted (Home Office approval letter attached at Appendix A)

1.4 Agencies who took part in this case Review are:

- Norfolk Constabulary - chronology and information plus a report from Firearms Dept.
- An NHS Norfolk Commissioning Support Unit for GP Practice - chronology & Independent Management Review
- Norfolk and Norwich Hospital Trust - chronology
- Norfolk & Suffolk NHS Foundation Trust – chronology & Independent Management Review
- Leeway Women's Aid Leeway Domestic Violence & Abuse Service, Norfolk – Panel member

Family, friends and colleagues have also contributed to this Review

1.5 The Review has followed statutory guidance issued for the conduct of Domestic Homicide Reviews (DHR). A total of 16 agencies were contacted to check for any involvement with the parties concerned in this Review. There were 11 nil returns and 5 returns confirming involvement. Of the agencies confirming involvement with the victim or perpetrator all submitted a chronology of their contact except one. The one agency who did not contribute to the chronology formally was a service which only provided equipment to aid Mrs A following an episode of surgery. The Police involvement was brief, but they were asked to provide a report in relation to item 6 of the Terms of Reference. The Norfolk & Norwich Hospital provided a chronology only as their involvement was brief and details of the victim's contact with them was detailed in GP records and was covered in the Independent Management Review for this service by the NHS Norfolk Commissioning Support Unit. The Mental Health Trust also submitted an Independent Management Review.

1.6 The chronology showed that the Police attended one suspected domestic abuse incident on 9 August 2011. This followed a 999 call from the victim who appeared to be distressed and saying "help me". The call taker commented at the time that it sounded as though her husband had attacked her; a male was heard in the background. Police attended and found both parties under the influence of alcohol. Officers interviewed the parties separately. The perpetrator denied any altercation had taken place or that there had been a call to the Police. He also tried unsuccessfully to request that the officers contact a senior officer he knew in the force who would "sort this out". The victim confirmed that a verbal altercation had taken

place, but would not confirm or deny that she had been assaulted and did not make a complaint. The incident was recorded as a verbal argument, non-crime, and as standard risk.

Purpose and Terms of reference of the review:

1.7 The purpose of the review is to:

- Establish the facts that led to the death of Mrs A and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard Mrs A.

- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.

- Establish whether the agencies or inter agency responses were appropriate leading up to and at the time of the fatal incident.

- Establish whether agencies have appropriate policies and procedures to respond to domestic abuse and to recommend any changes as a result of the review process.

- To seek to establish whether the events leading up to the deaths could have been predicted or prevented.

  Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

1.8 **Terms of Reference:**

1. To review the events and associated actions that occurred from 2005 up to the date of the death of Mrs A. Agencies with relevant knowledge of the victim or her husband before this time are asked to provide a brief synopsis of their involvement. Relevant knowledge would include such contacts as the Police; statutory and voluntary agencies contacted for support in connection with their relationship; mental ill-health.

2. To review the quality and scope of action/s and services provided by the agencies defined in Section 9 of the Act which had involvement with Mrs A and Mr B her husband and other individuals e.g. friends, extended family, or employers, as identified within the agencies' records, Individual Management Reviews (IMR) or other information sources as deemed appropriate by the Independent Chair of the DHR.

3. To examine the knowledge and training of staff involved in relation to the identification of indicators of domestic abuse and the use of appropriate risk assessment i.e. the DASH risk assessment checklist, agencies own specialist risk assessments, and knowledge and use of appropriate specialist domestic abuse services.

4. Examine the effectiveness of single and inter-agency communication and information sharing, both verbal and written.

5. To assess the extent to which agencies relevant policies and procedures were followed, and whether these are up to date and fit for purpose in assisting staff to practice effectively where domestic abuse is present.

6. The Police to examine whether procedures were followed, additional information sought from all Police data systems, and the certificate holder's GP response was received and appropriate to inform the decision to grant continuation of a shotgun certificate to the victim.

7. To involve the family, friends and if appropriate employers of Mrs A and Mr B. The overview report writer will be responsible for meeting with family, friends and employers to invite their contribution to the DHR.

2 Key Issues Arising from the Review:

2.1 Mrs A and Mrs B had been in a 20 year relationship, during the latter 10 years of which they where married. Mrs A was attractive, gregarious and 14 years younger than her husband. She has been described by some contributors to the Review as a 'trophy wife', and that Mr B was proud to have her on his arm. They were well known in their area and Mr B was very active in local activities. He was seen as an effective leader and was committed to his local community. He was also a member of a number of local organisations. The couple often attended events and functions related to Mr B's various roles. However, Mr B's public persona appears to be contrary to what took place in the couple's private life.

2.2 The couple had what was known among some of their friends as an 'open relationship'. Both had affairs although it is not possible to determine whether Mrs A was always a willing participant or whether this had always been a part of their relationship. During the Police enquiry following Mrs A's death an old diary and sheets of paper containing diary notes were found. The notes are not always dated and are sometimes disjoined, however, among the day to day recording of everyday life events Mrs A wrote of incidents of physical assaults and verbal put downs at the hands of Mr B. There is evidence in Mrs A's diary notes seen as part of this Review that she did not always agree to some requests made by her husband, and she was upset by one of his affairs conducted in front of her in their home.

2.3 In 2005 Mrs A first saw her GP for symptoms of depression; she was also suffering from insomnia. She linked this to suffering chronic pain caused by an accident. This was indeed an issue for Mrs A and a condition for which she would have further treatments at later dates. In 2006 she attempted suicide and told Accident & Emergency staff that she had relationship difficulties and was in love with someone else and her husband knew. Mrs A was admitted overnight and A & E passed this information on in a referral for her to have an assessment by the Mental Health Crisis Resolution Team. However, their assessment indicated that her attempt to take her own life was linked to suffering chronic pain. Mr B was present at this assessment. The subsequent letter from the Mental Health team updating Mrs A's GP did not mention relationship difficulties and therefore her GP was unaware of this aspect of their patient's life. Mrs A's relationship ended and she remained with Mr B.

2.4 Mrs A was referred for follow up in the community; however, the Community Mental Health Team refused the referral as a full assessment had not been completed. Mrs A's GP thought the suicide attempt was serious and followed this up, and at their request Mrs A was assessed at home and a plan for individual sessions with a Mental Health link worker were agreed. Mr B was present at this assessment. No relationship difficulties were recorded in this assessment, but Mrs A reportedly felt that her "self esteem had been destroyed". There is no record of the reasons for her low self esteem being explored and clinical notes for the 7 sessions she attended, and her GP records, are brief to none existent. This has made information gathering

and determining the rationale for treatments difficult for this Review. A Review recommendation has been made concerning this.

2.5 Mrs A saw her GP on a very regular basis. She was habitually accompanied by her husband to appointments. This was seen as Mr B being a supportive husband. The surgery also reported that a patient being accompanied by a relative is not uncommon among their older patients. The couple also had social connections with staff at the surgery. All these things combined, along with a lack of knowledge and training about domestic abuse, may explain why domestic abuse was never queried by the GPs Mrs A saw.

2.6 Mrs A had regular prescriptions for anti-depressants, but did not accept suggestions that she access counselling. She gave either chronic pain or work related stress as a reason for her depression. She had a period of prescriptions for anxiety and insomnia, as well as analgesia for her chronic pain. She also suffered from intestinal problems which were linked to irritable bowel syndrome. Alcohol use was discussed at appointments, and although Mrs A was on anti-depressants she appears to have continued to drink alcohol. The couple's social life often involved going to pubs, functions, and drinking with friends and so alcohol was intrinsically linked to their lifestyle. Mr B was also known to drink and drive and Mrs A would sometimes take steps to stop this from happening, but with limited success. Although there is evidence from her diary notes that she used alcohol on occasions thinking it would help her to sleep, she also recorded times when she was not drinking at all. Among the impacts identified as affecting the health of women experiencing domestic abuse are irritable bowel syndrome[1], gastrointestinal disorders and gynaecological problems, greater use of alcohol, depression, anxiety, insomnia, and suicidal ideation[2]; all problems experienced by Mrs A at various times to which a practitioner trained about domestic abuse and its health impacts might have given consideration.

2.7 In May 2007 Mrs A finished her sessions with the Mental Health link worker and she took up clay pigeon shooting as a hobby. In June 2007 Mrs A applied for a shotgun certificate and was visited as part of the licensing process by a Firearms Licensing Officer. Her depression was disclosed in a report by her GP who acted as her referee for the certificate. The certificate was granted under category B[3]. The Firearms Licensing Department was informed that she had purchased a 12 bore shotgun from a registered dealer in July 2007. In August 2009 the Firearms Licensing Department received notification from Mrs A that she had inherited 3 shotguns. Information provided to the Review states that the 3 shotguns were in fact purchased by Mr B as an investment and not owned by Mrs A. An officer was sent to make a reassessment of risk category and this took place in September 2009. This was to comply with the 2 year reassessment period from the time the certificate was first granted on 7 June 2007. In effect this meant that the reassessment took place 3 months late. It can only be assumed that Mrs A's gun cabinet was inspected to check that it could securely accommodate 4 shotguns during this visit as it is not recorded. Mrs A was still on anti-depressants but had improved. The category under which the certificate was granted was changed to category C and the certificate was then required to be renewed 5 years after it was first issued.

2.8 In mid 2010 to late 2011 their relationship appears tumultuous; Mrs A appeared to be very unhappy about her husband's continuing affair with another woman, and Mr B is critical of her level of drinking. Mrs A's diary indicates her drinking is due to the unhappiness she is feeling. However, contradicting his criticism, in July 2011 Mrs A's diary records that she

[1] Shipway L (2004) *Domestic Violence A handbook for health professionals*. Routledge, London.

[2] Golding JM (1999) *Intimate partner violence as a risk factor for mental disorders: a* meta-*analysis*, Journal of Family Violence, 14(2), 99–132.

[3] Category B is used where there is some minimal concern or some change in circumstances and will indicate that the certificate holder should be visited at least once in every two-year period.

was not drinking and Mr B came home drunk, poured a bottle of whiskey into a pint glass and told her to drink it.

2.9 On 9 August 2011 the Police received a 999 call from Mrs A's address. A distressed female on the line said "help me". The call taker could hear a male in the background. Two officers attended the address. Mr B invited them in, but he denied a call had been made or that an altercation had taken place. Mr B was assessed by the officers as being intoxicated. He said he had just arrived home and therefore there may have been another man in the house. Officer 1 went outside and checked that they had the correct address and this was confirmed. The officer returned to the house and told Mr B they would need to check on the welfare of Mrs A, and officer 2 went to interview her. Officer 1 interviewed Mr B who denied anything had occurred and he requested that the officer telephone a named senior Police officer saying "he will sort this out". Officer 1 refused. Officer 2 requested that officer 1 join them in interviewing Mrs A who was in bed and also appeared to be intoxicated. Mrs A admitted that she had called the Police, but there had been a verbal altercation only. She refused to confirm or deny that she had been assaulted. Police databases were checked and there were no previous incidents recorded; there was no visible evidence of assault and no complaint made to enable further action. A DASH[4] risk assessment was calculated at 'standard' risk. Mr B subsequently made a complaint about the attending officers which was not substantiated. Officers attending were unaware that a shotgun certificate holder was resident at the address or that there were shotguns at the property. In her diary note for the evening of 9 August 2011 Mrs A confirmed that Mr B had assaulted her and she recorded the Police visit. She wrote that he had "hit me a lot. He went to town. We had the Police around because Mr B had a good time with me!!!" She also recorded that Mr B was drunk and so she was not going to run him down, and that they were both under the influence. The fact that Mrs A dialled 999 for the first time indicates that the assault level may have been more severe than before or she was particularly frightened at the time.

2.10 Mrs A's diary notes relevant to this Review indicate a relationship of ups and downs, not unusual in relationships, but her notes indicate that the 'downs' were accompanied by abusive behaviour by Mr B that ranged from hitting her, throwing things at her, swearing and cursing at her, putting her down and ignoring her. The earliest entry in 2000 recorded that Mr B did not seem bothered that he hurt her; and he had replied that she either "like it or lump it, he ain't going to change". Records of abusive acts are inter-disbursed with notes saying how much she loved Mr B, and on one occasion what a lucky woman she was when a particular holiday was booked. In November 2010 Mrs A recorded that she had cancelled going into work as her husband had been "too happy hitting me" and he had said she deserved to be hit. Employment records confirm that Mrs A did not go into work the following day. In February and March 2011 Mrs A's diary notes indicate diverse views in how she sees her relationship with her husband. One week she recorded that she is frightened of Mr B because of his actions, and the next she expresses fond feelings for him, but by the end of March 2011 things appear to be tense once more, and she recorded that everything she did was wrong in his eyes. The last diary note recording an assault by Mr B was on 24 June 2012.

2.11 In May 2012 Mrs A's shotgun certificate was due for renewal and a visit was made by the Firearms Enquiry Officer. There were no identified problems and the certificate was renewed. It was recorded that no ammunition was kept in the house. Mrs A said she bought cartridges at clay shooting venues. Only one of her 4 guns was used for shooting. A friend of Mrs A and Mr B was the referee for the renewal application. A routine letter was sent to Mrs A's GP practice asking them to inform the Firearms Department if there were any concerns about granting the renewal. There was no response to this letter. The 999

[4] Domestic Abuse Stalking & Harassment (DASH) risk assessment. An evidence based list of questions to assess the level of risk faced by a victim of domestic abuse used by Police and multi-agency referrals to Multi-Agency Risk Assessment Conferences (MARACs).

call to the suspected domestic abuse incident on 9 August 2011 came to notice during the vetting procedure when Police databases were searched. There is no indication that this was discussed with Mrs A during the home visit in May 2012, however, the incident would not have prevented the certificate being renewed under regulations in force at this time.

2.12 The day before her death Mr B had thrown Mrs A out of the couple's home. He is alleged to have told friends that Mrs A was impeding his career. He also is alleged to have said to Mrs A that she would get nothing. Mrs A was taken to the home of a friend with whom she had recently started a relationship which was known about by Mr B. Some contributors to the Review commented that Mr B suggested to the man concerned that he take Mrs A out while he, Mr B, was out at weekends. Mrs A told the friend that she was thinking of leaving her husband. They discussed options including Mrs A leaving the area and living elsewhere. The following day Mr B phoned Mrs A wanting to see her. He assured her he would not hurt her. Mrs A's friend wanted to go with her, but she thought his presence would inflame the situation and so he dropped her off near her home and last saw her talking to Mr B. At 2.48pm that day Mrs A called 999 to say her husband was pointing a gun at her threatening to shoot her. Police and paramedics attended, but found Mrs A shot dead. Mr B was found dead in the back garden of their home with the shotgun beside him. He had an injury consistent with a self inflicted shotgun wound.

3 Conclusions:

3.1 A primary purpose of the Domestic Homicide Review in addition to identifying actions taken and lessons to be learnt is to determine whether the homicide was predictable and preventable. The information available to agencies at the time of the incident would not have enabled them to predict the terrible event which led to Mrs A's death. That Mrs A had experienced domestic abuse for many years at the hands of her husband was unknown to them. His public persona and high standing in the community may also have made it unthinkable that he was abusing Mrs A in the privacy of their own home, and indeed there is still incredulity in some quarters that Mr B shot Mrs A and then took his own life.

3.2 There is evidence to suggest that Mr B planned to shoot Mrs A on the day she returned to the couple's home to discuss their future. He had laid out the couple's Wills and left instructions for his funeral. It is likely that he had obtained the shotgun from the gun cabinet before she arrived, for if she had seen him get the keys and go to the cabinet she may well have had the time to escape to a safe distance. Agencies could not have prevented her death that day.

3.3 Unknown to Mrs A was the fact that high up the risk assessment scale for the risk of serious harm or homicide in domestic abuse cases is the time of separation and leaving a relationship. The fact that she was finally contemplating leaving Mr B took her into this high risk category.

3.4 If Mrs A been supported to disclose the abuse she was suffering to professionals and they and the friends she had disclosed to had had information about domestic abuse, the risks faced by victims, and where to go for support, there is a chance she might have been persuaded to accessed this help and safely separate from Mr B.

3.5 Lessons to be learnt

3.6 One of the main lessons to be learnt by professionals from this case is the need to suspend all disbelief that a person who is high profile and seen as doing good in their community cannot be a perpetrator of domestic abuse. Domestic abuse takes place in all stratus of society. It is possible that Mrs A had come to not only accept her way of life, but the position her husband held may have put addition pressure on her not to seek help. This emphasises even more sharply the importance of a wide range of professionals having knowledge about domestic

abuse which enables them to recognise signs and symptoms which may indicate abuse is taking place, and to be able to help a victim to disclose their experiences safely and be referred on for specialist support. Health professionals in particular are often viewed by their patients as someone they can trust and confide in, but circumstances need to be created which enable them to do this with confidence and safety, and professionals need to be equipped with the skills to act appropriately.

3.7 Strategic level leadership is needed to drive forward the domestic abuse agenda in the county across all agencies, but particularly in Health and Public Health. Staff need not only the policies and procedures to guide their practice, they need training and to work in an atmosphere of supportive supervision for the risk assessments they have to make and the decisions they take. A culture of inter-agency working across statutory and specialist voluntary sector organisations should prevail.

3.8 Victims need to be given a safe and confidential space on their own with Health professionals so that they have the opportunity to disclose domestic abuse if they wish. It is particularly important that they are seen alone for assessments, where the patient is suffering from depression, or where research may suggest possible health or ill-health indicators of abuse.

3.9 Interviews undertaken by the Police and the Review author reveal that Mrs A had disclosed to some friends that she had been abused by Mr B for some years, however apart from the 2011 incident when she called the Police no other reports of abuse had been reported to them. This is not unusual; as highlighted in research women can experience up to 35 assaults before calling the Police[5], therefore it is important that domestic abuse incidents are seen in this context. A victim in Mrs A's position would probably not have felt able to disclose the assault she suffered with her husband in the house, albeit Officers acted according to best practice in interviewing them separately. Even though it is routine practice to provide support telephone numbers and information to a victim when attending an incident, a follow-up phone call at a safe time when the perpetrator is not present would be an additional act of best practice, most particularly when alcohol has been consumed and the victim may not have taken in all that was said to them.

3.10 Assessing only the person who is to be the firearms certificate or shotgun certificate holder when considering the granting of a gun certificate does not in itself limit the risk of a gun being misused. This case demonstrates that there is a great deal of trust placed in the applicant to ensure that others in the household do not have access to the weapon and ammunition to use it. Mr B knew where the keys were to the gun cabinet and had access. By this fact he too should have been assessed to be granted a gun certificate. One might argue that gun legislation is still too liberal and Chief Officers have little discretion to refuse to grant a certificate. There is a strong argument for a more robust approach to assessments for granting and renewing licences and certificates.

3.11 There is a tendency to think that domestic abuse does not happen in affluent areas, and it does not happen in relationships such as Mrs A's and Mr B's. Yes, the couple had good times together, but this was interrupted by incidents of abuse over the years. This case graphically demonstrates how the public face of an individual can be very different to the one behind closed doors. Abuse does not just happen in relationships in a certain sector of society. It is taking place in rural and urban areas, deprived and affluent areas, and across all ages and backgrounds. The phrase "it doesn't happen here" needs to be dispelled and information needs to be available across the county for professionals, families, friends and colleagues to help them identify domestic abuse, what constitutes increasing risk to victims, and where to go for help.

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5 Jaffe P, Burris C. (1982) *An Integrated Response to Wife Assault: A Community Model.* Cited in Dutton D. (2006) *Rethinking Domestic Violence*. Vancouver BC, USC Press [5]

4 Recommendations:

4.1 The following recommendations have been informed by the Independent Management Reviews and the Overview Report writer's assessment. A number of the recommendations relate to the clinical management of a patient's care rather than specifically to domestic abuse, but they are included here for the benefit of additional learning for those working in the relevant agencies.

National level:

4.2 **1.** That NHS England build into its contractual and performance management arrangements a requirement that GP practices should implement the Identification and Referral to Improve Safety (IRIS) system in coordination with Independent Domestic Violence Advocacy Services[6].

4.3 **2.** That NHS England support primary care services to be more aware of their responsibilities to share relevant information which is required to ensure the safety of their patients and members of the public.

4.4 **3.** That there is a national review of the Firearms (Amendment) Act 1997 Section 37 (26B) Applications for shot gun certificates, to include the criteria by which an individual is granted a shotgun certificate. Such criteria should include:

(a) A definition of a 'fit and proper person' appropriate for being granted a certificate or licence and that it is not a person's right to have a shotgun certificate, but that they have to demonstrate they are a fit and proper person to be granted a certificate.

(b) A requirement to have a medical before the granting and renewal of a shotgun certificate paid for by the applicant. No certificate should be granted before a satisfactory medical is received, and the onus is on the applicant to ensure that this is received by the Firearms Licensing Department in the time required.

(c) The checking of Police records and risk assessment of members of the household of applicants.

(d) The prohibition of the granting or renewal of a certificate where the applicant or associated person/s has involvement or association with violence or domestic abuse.

(e) Whilst gun security is already in the regulations this should be given greater prominence in the declaration so that the certificate holder is clear of their responsibilities to ensure that gun cabinet keys are separately secured and not available to anyone else in the household who is not also a certificate holder. Confirmation of the keys secure location should be part of the inspection process. Failure to comply with this regulation should be an offence, and unlawfully accessing the keys by a third party should be an offence.

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[6] Howell A, & Johnson M (2011) *IRIS Identification & Referral to Improve Safety: The IRIS solution – responding to domestic violence and abuse in general practice*. University of Bristol
http://www.irisdomesticviolence.org.uk/holding/IRIS_Commissioning_Guidance.pdf

NB Please see section 5 page 12 for additional information which was published by the Home Office concerning revised Guidance for Firearms legislation after this Review was completed which relates to this recommendation

National and County level:

4.5 **4.** Training for Health professionals including Mental Health, GPs, and other primary care staff should include mandatory training about domestic abuse separate from safeguarding training. This training should be a rolling programme to encompass new staff and be commenced within 6 months of the publication of this Review. It should include:

(a) The identification of domestic abuse, risk assessment, how to engage with patients who may be at risk by being able to ask questions safely and sensitively, and knowledge of specialist support agencies to whom they can refer.

(b) An awareness of the evidence base, health markers, and links between domestic abuse and depression, and other medical conditions;

(c) An awareness of domestic abuse perpetrator profiles to assist in the identification of high risk behaviours and when and to whom to provide information should a patient's behaviour cause risk to others. Knowledge of support for perpetrators who wish to change their behaviour should be included and referral routes.

4.6 **5.** That all Health agencies and GP practices develop domestic abuse policies and protocols within 1 year of the publication of this Review which clearly outline the responsibilities of staff to understand and respond to the needs of domestic abuse victims. The policies and protocols should be mindful of the Home Office definition of domestic abuse which was amended in March 2013[7] to include individuals of 16 years and over, and the inclusion of coercive control in the description of abuse. Policies and protocols should include:

(a) A domestic abuse care pathway as recommended by the Royal College of General Practitioners, IRIS, and CAADA: this can be found at http://www.rcgp.org.uk/clinical-and-research/clinical-resources/domestic-violence.aspx

(b) The identification of a key individual within the agency or practice who will have additional training and be able to act as more specialist support for other staff.

(c) Where an individual is regularly accompanied by a partner, relative or carer a policy should be put in place setting a clear expectation that opportunities will be made available to see individuals alone in a safe and confidential setting. Advice and guidance on how to achieve this should be included.

(d) At the time of writing NICE are in the process of developing guidance to support the prevention and reduction of domestic violence which is due to be published in February 2014. It is proposed that Clinical Commissioning Groups take forward NICE recommendations with its membership at that point.

NB Please see section 5 page 12 for additional information which was published by NICE after this Review was completed and which relates to the Health recommendation in the Review.

4.7 **6.** GPs would find it useful to access the Royal College of General Practitioners e-learning course for guidance and practice advice regarding domestic violence. This is available on the

[7] www.gov.uk/domestic-violence-and-abuse

Royal College's website at: http://elearning.rcgp.org.uk (enter domestic violence in the search for courses window).

County level:

4.8 **7.** That the Director of Public Health and a leading Practitioner for the county Clinical Commissioning Groups provide leadership to drive forward Health's contribution to an integrated multi-agency domestic abuse strategy for the whole county by June 2014.

4.9 **8.** Information about domestic abuse, helplines, and routes to support locally and nationally should be provided for victims, family members, friends and work colleagues. This information should be widely available in a variety of venues throughout rural and urban communities. The information should include identifying the signs of domestic abuse, what constitutes increased risk to victims, and where to go for help. It should be available in a variety of formats, including a size which can be easily given discretely and safely to victims at the time of an incident, consultation, or disclosure to a friend. The materials should be available and displayed across the county by January 2014.

4.10 **9.** GP Practices should provide a protocol for staff involved in patient care by December 2013 which clarifies expectations relating to written record keeping, and the maintenance of electronic records which should provide a high level of detail and information pertaining to the treatment and assessment of patients; include the rationale for decisions making; outlines what is offered to patients along with reasons for options being declined, but most importantly offers a clear chronological account of care provided.

4.11 **10.** The following are recommended when assessing and monitoring patients suffering from longstanding depression and should be disseminated throughout GP practices and Mental Health providers and commissioners by December 2013:

(a) NICE Guidance[8] is available to support the management of Depression in Adults and Depression in Adults with Chronic health problems and should be utilised as this provides a clear, structured and tested framework. If there is variance to the guidance a rationale for decision making should be documented within a patient's clinical records to clarify choices and options made.

(b) A clear risk assessment process should be undertaken for patients with depression which gauges the behaviour of a patient and determines how they may react to various methods of treatment. It should identify the level of depression and identify any suicidal ideation; this is clearly stated within NICE Guidance. Treatment options and onward referral should be structured to fit appropriately with the patient's level of need determined from risks assessed. For example where depression and substance misuse are found to coexist a coordinated treatment plan addressing both conditions should be explored.

(c) Where treatment of depression is being managed between primary care and mental health community or secondary care services, information should be complete and accurate, providing a clear chronology of case management activity, treatment and actions taken through the duration of input. The GP is always a central professional in sustaining care for an individual and therefore must be in receipt of all information that will allow them to effectively manage and consider patients future needs.

4.12 **11.** The Community Safety Partnership should monitor the progress and impact of the protocol between the Safeguarding and Firearms Units introduced in mid 2013 concerning

[8] National Institute for Clinical Excellence (NICE) Guidance (CG91 2009 Treatment of Depression in Adults with Chronic Health Problems and Depression in Adults updated 2009)

domestic abuse and checking firearms databases to ensure that it is able to be implemented effectively in practice. The Partnership may wish to be made aware on an annual basis of the effect of this policy vis a vis the number of licences or shotgun certificates revoked due to incidents of domestic abuse.

4.13 **12.** The Community Safety Partnership should support and monitor the implementation of domestic abuse policies within Health partner agencies and give appropriate 'expert' guidance from board partners from the specialist domestic abuse sector to ensure that policies meet the needs and safety requirements of victims and survivors of domestic abuse.

4.14 **13.** Information sharing protocols should be reviewed to ensure that all agencies have appropriate agreements in place for the timely and accurate sharing of information. This is particularly the case for the sectors within Health and Mental Health who have undergone radical restructuring in recent months. This review should be completed by October 2013. Any necessary amendments to protocols should be completed by January 2014.

4.15 **14.** The Police should ensure that all frontline Officers and the relevant support staff complete training in the DASH risk assessment, its use with victims and the evidence base behind the risk factors. Training should include ensuring that firearms are included when asking questions about weapons.

4.16 **15.** Where a victim is found to be under the influence of alcohol or other substances at the time of investigating an alleged incident of domestic abuse, a call should be made the following day, or as soon as practicable, to follow-up the incident and to provide advice when the victim is unaffected by substances and the perpetrator is not present.

5.0 Additional information received after completion of the Review

5.1 In August 2013 the Home Office published the Guide on Firearms Licensing Law[9]. This Guide revises previous guidance and includes specific instructions where domestic abuse is known or suspected in the household of a firearm or shotgun certificate holder. Chapter 12 paragraph 12.40 stipulates that following any incident of domestic violence or abuse a review should take place as to the continued suitability of the certificate holder.
The guidance also includes the following:

- When police officers receive information about an applicant having a history of domestic violence, they should consider interviewing their family, friends and associates.
- Speaking to the applicant's partner – who might be a victim of abuse – may be judged to be "essential".
- The information the partner gives must be treated confidentially and police would need to take steps to make sure they are safe from possible reprisals.
- The partner would not have to approve an application for a firearms certificate – that responsibility would still lie with the police, who would also consult their own force's domestic violence unit.

The guidance also confirms that the police would not have to rely on a criminal conviction for domestic violence when considering applications. They would be able to consider police intelligence about an incident, looking at how recent it was and whether it was isolated behaviour or part of a pattern. This Guidance is welcome and goes some way to improving safety for those experiencing domestic abuse, however, it makes the assumption that the perpetrator of abuse is always the certificate holder whereas the victim was the certificate

[9] https://www.gov.uk/government/news/new-firearms-guidance-on-domestic-violence-published

holder in this tragic case. This Review recommendation that the medical process and confirmation on suitability by GP's be strengthen has not yet been adequately addressed in the revised Guidance.

5.2 At the beginning of August 2013 the National Institute for Health and Care Excellence issued a draft Public Health Guidance for consultation. Domestic Violence & Abuse: how social care, health services and those they work with can identify, prevent and reduce domestic violence and abuse[10] makes 17 recommendations for changes within Health and social care. A number of the recommendations made in this Review are also recommendations within this Guidance. This includes a call for an integrated care pathway for identifying, referring and providing support to those experiencing domestic abuse and those perpetrating it. A further recommendation advocates the creation of an environment for those affected to disclose domestic abuse, and includes the need to display information in various formats. Encouragingly, the draft Guidance also recommends training for all levels of staff from GPs to reception staff, and the inclusion of domestic abuse in pre-qualifying and continuing professional development for Health and social care professionals. If this Guidance is adopted and implemented many of the Health recommendations in this Review would be met.

[10] http://www.nice.org.uk/guidance/index.jsp?action=download&o=64783

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Ms Laura McGillivray
Chair of Norfolk County Community Safety Partnership
City Hall
Norwich
NR2 1NH

23 August 2013

Dear Ms McGillivray,

Thank you for submitting the report from Norfolk to the Home Office Quality Assurance (QA) Panel. The review was considered at the QA Panel meeting in August as agreed.

The QA Panel would like to thank you for conducting this review and for providing them with the covering letter, overview report, action plan and executive summary. In terms of the assessment of reports the QA Panel judges them as either adequate or inadequate. It is clear that a lot of effort has gone into producing this report, and I am pleased to tell you that it has been judged as adequate by the QA Panel.

There are a few issues that the QA Panel felt would benefit from consideration before you publish the final report:

- Consider including a reference to substance misuse in recommendation 10(b);
- Removal of the personal information on the victim and the perpetrator from the direct quotes from the diary notes of the victim;
- Update the sections relating to health recommendations and gun control given the recent publications in respect of their interface with domestic violence cases;
- Attempting to further anonymise the report as all identifiable references including the date of death, should be removed in order to protect identities and comply with the Data Protection Act 1998, in accordance with paragraph 9.2 of the Statutory Guidance for the Conduct of Domestic Homicide Reviews.

The QA Panel would like to commend you on the following that were considered to have been done very well:

- The report was thorough, well written and demonstrated a clear understanding of the dynamics of domestic abuse;

- The report clearly draws on the information provided in the IMRs, and lessons learnt appropriately link to, and emerge from, the analysis of the information provided;
- Given that not all family members were aware of the nature of the relationship between the victim and the perpetrator the author has handled the presentation of this information with care and sensitivity; and
- Despite very limited agency contact, the Chair has conducted a thorough investigation to extract all useful learning in this DHR.

The QA Panel does not need to see another version of the report, but I would ask you to include this letter as an appendix to the report when it is published.

Yours sincerely,

Mark Cooper, Chair of the Home Office Quality Assurance Panel
Head of the Violent Crime Unit