Domestic Homicide Review

EXECUTIVE SUMMARY OF THE OVERVIEW REPORT

Into the death of Mrs A and Mr B

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Section One: Introduction

This Domestic Homicide Review examines the circumstances surrounding the death of adults Mrs A and Mr B.

1.1 At 0800hrs on Saturday 2nd March 2013 the victim Mrs A, who had previously been in a relationship with Mr B, the perpetrator and had remained friends with him, received a telephone call from him, asking her to go to his house as he was vomiting and bleeding.

She left her home immediately and arrived at his house at 0840hrs. Almost immediately after her arrival, two gunshots were heard followed closely by a third.

Police were called to Mr B's home address following a report that a witness had located the bodies of two people in the porch/hallway of the address.

Upon police arrival, the bodies of Mrs A and Mr B were found inside the address. Both had sustained fatal gunshot wounds. A shotgun was found near to Mr B's body.

Police enquiries have determined that there were no other persons involved in this incident. Mr B had been the holder of a shotgun licence and owned four shotguns.

1.2 The background is:-

At the time of their deaths Mr B was 59 years of age and Mrs A was 58 years of age.

They had known each other since they were at school and had remained close friends. Both were divorced and each had two grown up sons. Sometime after Mr B's divorce, their friendship changed into a romantic relationship, although they never lived together.

Mr B had retired from the Police, as an Inspector, in January 2008 and had immediately taken up a senior civilian post with the Ministry of Defence, reporting directly to an Army Brigadier. Initially he settled well into his new role and was well thought of, however with cut backs, his role changed and on 4th February 2013 he was seen by his line manager regarding his performance in some areas of his work. Whilst he seemed to take the criticism well, he later learnt that a comment had been made that "he was the highest paid civilian but did the least work".

The following week he reported sick, with a doctor's certificate for insomnia and anxiety. He was treated with anti-depressants, although his prescription was changed four times within 19 days. He asked to be referred to a

counsellor but as his GP did not recommend it, at that stage, he referred himself to a counsellor for one private consultation. His eldest son (his next of kin) asked for him to be sectioned but his doctor did not agree to this.

During police interviews after the deaths, Mr B's ex wife claimed he had physically assaulted her on two occasions prior to their divorce and that while she had reported both assaults to the police no action was taken. A retired police officer has confirmed one of the two incidents of domestic abuse. Statements taken from friends have recounted that Mr B was often verbally abusive to Mrs A.

Section Two: The Review Process

2.1 This summary outlines the process undertaken by the Domestic Homicide Review Panel in reviewing the murder of Mrs A and death of Mr B.

2.2 A Domestic Homicide Review (DHR) was recommended and commissioned by the Wiltshire Community Safety Partnership 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 2011.

2.3 The Home Office was informed of the intention to conduct a DHR on the 2nd April 2013.

2.4 The process began with an initial Review Panel meeting on 8th May 2013 of all agencies that potentially had contact with the victim Mrs A and the perpetrator, Mr B prior to the point of death.

2.5 The families of both the victim and perpetrator were contacted at the start of the Review. The two sons of the victim and one son of the perpetrator provided key information and questions which the Panel and Individual Management Report (IMR) authors considered. The eldest son of the perpetrator did not wish to be involved with the Review and his brother later decided not to respond as both were concerned that their father's actions may be construed to be domestic abuse rather than as the outcome of a mental breakdown. The sons of the victim were consulted by the Independent Chair during the preparation of this overview report. The family of the victim were provided with specialist support from the Homicide Support Service. They were also offered support from AAFDA but declined. Three of Mrs A's friends and three of Mr B's work colleagues were consulted by the DHR Chair during the Review. At the conclusion of the Review they were informed about the lessons learnt and recommendations made.

2.6 On 13th August 2013 the victim's sons, while accompanied by the Homicide Support Service worker, were shown the completed overview report. They expressed their thanks for the thoroughness of the Review and their satisfaction with the conclusions and action plans.

2.7 The agencies participating in this case review are:

Avon & Wiltshire Mental Health Partnership NHS Trust (AWP)
NHS Wiltshire Clinical Commissioning Group
An Independent Counselling Company
Relate
Royal Military Police
Splitz Support Service
Wiltshire Council Housing Allocations & Options
Wiltshire Council – Revenue & Benefits
Wiltshire Fire and Rescue

Wiltshire Police
Wiltshire Probation Trust
Victim Support
The Multi –agency partnerships:
Wiltshire Community Safety Partnership (CSP)
Wiltshire Safeguarding Vulnerable Adults Board
Wiltshire Multi- Agency Risk Assessment Conference (MARAC)

2.8 Agencies were asked to give chronological accounts of their contact with the victim and perpetrator prior to the deaths. Where there was no involvement or insignificant involvement, agencies advised accordingly. In line with the Terms of Reference, the DHR has covered in detail the period from 1st January 2008 to 2nd March 2013, although the Police has highlighted an allegation of domestic abuse in 1998.

2.9 Each agency's report covers the following:

A chronology of interaction with the victim and/or the perpetrator; what was done or agreed; whether internal procedures were followed; and conclusions and recommendations from the agency's point of view to address those issues set out in the DHR Terms of Reference.

2.10 The accounts of involvement with the victim and/or the perpetrator cover different periods of time prior to the victim's death.

Some of the accounts have more significance than others. The extent to which the key areas have been covered and the format in which they have been presented varies between agencies.

2.11 Fifteen agencies/multi-agency partnerships were contacted about this review. Eight have responded as having had no contact with either the victim or the perpetrator. They are:

Relate
Splitz Support Service
Wiltshire Fire & Rescue
Wiltshire Probation Trust
Victim Support
The Multi–agency partnerships:
Wiltshire Community Safety Partnership (CPS)
Wiltshire Safeguarding Vulnerable Adults Board
Wiltshire Multi-Agency Risk Assessment Conference (MARAC)

2.12 Four have responded with information indicating some level of involvement with the victim Mrs A. None of the contacts were relevant to the homicide. They are:

- NHS Wiltshire and Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) whose contacts were restricted to medical records.

- Wiltshire Council (Housing Allocations and Options) and Wiltshire Council (Revenue and Benefits), both of these departments contacts relate only to housing issues.

2.13 The six organisations that completed either an IMR or a report have responded with information indicating some level of involvement with the perpetrator Mr B:

- Wiltshire Council (Housing Allocations and Options) and Wiltshire Council (Revenue and Benefits), both of these departments contacts relate only to non-relevant housing issues.

- NHS Wiltshire GP service had regular contacts with Mr B in relation to his general health needs but only those from 6th February 2013, (eleven) had any relevance to the events that led to his death and that of the victim on the 2nd March 2013. The contacts detail the GP consultations and treatment for insomnia, low mood and anxiety. The Doctor's notes includes a diagnosis of mixed anxiety and depressive disorder listing possible causes as being high workload and his mother's bereavement. There is no indication of suicidal tendencies.

  On 8th August 2011, the surgery had been informed by letter from the Wiltshire Police Licensing Department that Mr B had recently had his shotgun certificate renewed and had immediate access to firearms and ammunition. Mr B's GP was asked in the letter if the renewal of the licence caused him any concerns for the safety of any person, including the certificate holder; but it went on to state that if there were no concerns, then in line with the agreement with the BMA, the GP did not need to retain the letter.

  The IMR was comprehensive and included expert opinion from a specialist toxicologist, with regard to the possible effects of the mix of the drugs he was prescribed over a short period of time.

- Wiltshire Police included information that Mr B had served as a Wiltshire Police Officer until January 2008.

  The IMR author has diligently included information obtained from Mr B's divorced wife, relating to two incidents of domestic abuse, which occurred earlier than the period covered in the Terms of Reference. In an interview with police officers, following his death, she told officers that in 1997/8 whilst they were in the process of divorcing, he had been physically violent to her on two occasions. She gave details of the assaults and recounted how afraid she was. She stated that she had

reported the assaults to the police at the time, but felt she was discouraged from pursuing the assaults further. At the request of one of her sons, she later, refused to sign a statement prepared by the police, that detailed the two assaults, on the grounds that they were historic and were in her son's opinion, not relevant to the deaths.

The IMR author has thoroughly searched all police records of the time, but has not been able to find any official papers relating to these allegations. However a retired police officer has made two statements confirming one of the incidents.

The IMR points out that the way that the Police deal with incidents of Domestic Abuse has changed considerably since 1998. Officers are now encouraged to take positive action when Domestic Abuse is reported, to record occurrences and apply the DASH Risk Assessment model. The policy which is readily available to officers on the Wiltshire Police intranet site is currently being amended as a consequence to this Review.

The IMR author has included statements obtained from three friends of Mrs A which detail their personal knowledge of the relationship between Mrs A and Mr B, and what in their opinions was Mr B's often inappropriate behaviour towards Mrs A.

The IMR goes on to confirm that Mr B legitimately held a shotgun licence in respect of four shotguns. It explains the process whereby the firearms licensing department, at the time of issuing a licence, write to an applicant's GP to ascertain if there is any cause for concern relating to a firearm/shotgun certificate being issued or renewed. The IMR highlights that as a result of an agreement with the BMA, GPs are advised that they need not retain the letter if there is nothing to disclose at that time.

- Royal Military Police were asked by the review chair for a report, after family members of both Mrs A and Mr B, stated that Mr B had been depressed because of the way his line manager, a Brigadier in the Army had spoken to him about some of his work being below par.

  The report supported by statements taken by the police from the Brigadier and from work colleagues of Mr B, indicates that due to structural changes within the Brigade, Mr B was finding it difficult to carry out all of the responsibilities expected of him and that his line manager was right in raising this informally with him. Colleagues confirmed that they saw him come out of the meeting accompanied by the Brigadier and that they were both laughing and speaking amicably. It was only later when he was told by a third party that it had been said he was "the

best paid civilian but doing the least work" that he became quiet and worried.

The report author has referred the allegations of the families to the Director Personnel Services (Army) for consideration of any internal inquiry that may be considered necessary to identify organisational learning. The director of Personnel Services has determined that there are no grounds for any further internal enquiry (appendix D).

- An Independent Counselling Company has provided a report detailing Mr B's single counselling session with an Independent Counsellor at 2.30pm on 21st February 2013. During the consultation Mr B stated he had not been sleeping for about ten days and that he was signed off work. He told her, he was "plagued" by comments made by a colleague that "he was one of the highest paid Civil Servants in the establishment but that he was not performing."

  Whilst he lived alone he told her, he had a strong support network from his family and from Mrs A who regularly brought him meals. As part of the session he was asked if he had thoughts of self harm or suicide but he said "no" with the explanation that he could not do that to his family. He was in regular contact with his GP and whilst he arranged to attend for a second consultation he later cancelled on the grounds that his GP had changed his medication and told him that this form of counselling may not be suitable for him at this time. There was no further contact and no lessons to learn.

Section Three: Terms of Reference

3.1 The purpose[1] 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 organisations 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.

3.2 Overview and Accountability:

The decision for Wiltshire to undertake a Domestic Homicide Review (DHR) was taken by the Chair of the Wiltshire Community Safety Partnership on the 22nd March 2013 and the Home Office informed on 2nd April 2013.

The Home Office Statutory Guidance advises where practically possible the DHR should be completed within 6 months of the decision made to proceed with the review.

Although there is a pending Coroner's Inquest, a decision has been agreed, in conjunction with the Coroner, that once the police have completed their investigation and forwarded their file to the Coroner, the review can continue. The Home Office are aware that this short delay may result in the completion of the DHR being longer that 6 months but less than 9 months. The review will continue prior to the conclusion of the Inquest.

This Domestic Homicide Review which is committed, within the spirit of the Equalities Act 2010, to an ethos of fairness, equality openness, and transparency, will be conducted in a thorough, accurate and meticulous manner.

3.3 The Domestic Homicide Review will consider:

3.3.1 Each agency's involvement with Mrs A aged 58 and Mr B aged 59 from the 1st January 2008 to the 2nd March 2013, when the deaths occurred at Mr B's

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

home. However the Police have included within their review two incidents prior to 2008.

3.3.2 Whether the alleged perpetrator had any previous history of abusive behaviour towards the victim, or any previous partner and whether this was known to any agencies.

3.3.3 Neither Mrs A nor Mr B had any known contact with any specialist domestic abuse agency or service in the County. The Review will therefore consider if there were any warning signs locally which were not acted upon.

3.3.4 Whether family, friends, colleagues or employers want to participate in the review. If so, ascertain whether they were aware of any abusive behaviour from the alleged perpetrator to the victim or any other person, prior to the homicide.

3.3.5 Whether, in relation to the family members, were there any barriers experienced in reporting abuse?

3.3.6 Could improvement in any of the following have led to a different outcome for Mrs A: -

(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.

3.3.7 Whether the work undertaken by services in this case are consistent with each organisation's:

(a) Professional standards

(b) Domestic abuse policy, procedures and protocols

3.3.8 Whether practices by all agencies were sensitive to the nine protective characteristics of the Equality Act 2010 including age, disability, gender reassignment, marriage/civil partnership, pregnancy and maternity, race, sex, sexual orientation, religious belief of the respective family members and whether any specialist needs on the part of either of the subjects were explored, shared appropriately and recorded.

3.3.9 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.

3.3.10 The Review will consider any other information that is found to be relevant.

Section Four: Key Issues

4.1 The DHR provided an opportunity to analyse information obtained from agencies and from family and friends.

4.2 The core issues the panel reviewed are:

- Mr B's mental health in the weeks prior to and up to the time of the deaths.

- His GP's use of anti depressants; the four prescription changes made over a short period of time (17 days) and the possibility of side effects of combining these drugs over such a period.

- The GP was not aware of section 13.4 of the Mental Health Act 1983, which states that it is the duty of a Local Social Services Authority if so required by the nearest relative to make arrangements for a mental health assessment . If the decision is not to have such an assessment the nearest relative should be informed in writing. This was not explained to the deceased's eldest son who made the request to the GP.

- His employment with the MoD and the manner in which his line manager spoke to him on 4th February about his work performance.

- The effect his mother's death had on him, particularly after January 2013 when he returned from a visit to family in Australia which he had last made with his mother, with whom he was very close.

- His access to firearms (four shotguns) whilst he was suffering from depression. Mrs A had asked him for the keys to his firearm cabinet, which he had given her, without informing her that he had a second cabinet.

- The protocol between police and GPs whereby the police licensing department at the time of issuing or renewing a firearm/ shotgun certificate, write to the applicant's GP to enquire if the issue of the licence raises any cause for concern. The GP in line with an agreement with the BMA is told in the letter that if there are no concerns then the letter should be destroyed as confidential waste. Mr B's GP had received such a letter during the summer of 2011 when his shotgun licence was renewed. There was no obligation on the GP to make a record of his access to firearms.

- Mr B’s attitude/behaviour towards Mrs A and two incidents of physical violence on his ex wife at the time of their divorce.

- The Police IMR author could find no records relating to those incidents of domestic abuse in 1998.

Section Five: Lessons to be learnt

5.1 Of the four agencies that had contacts which were directly relevant to the homicide two have identified lessons they have learnt from the review.

5.2 The NHS Wiltshire IMR has identified three lessons:

- The combination of the drugs prescribed to Mr B over such a short period of time could have caused unexpected side effects.
- The GP was not aware of section 13.4 of the Mental Health Act 1983 which states that a next of kin has the right to instruct a mental health assessment.
- The current protocol between police and BMA relating to letters being sent to GP practices asking if there are any concerns regarding the issue or renewal of a firearm licence is not fit for purpose.
- The Panel believes this IMR is a good example of how a core service provider, by reviewing their contacts, from the perspective of the victim, identify and implement ways to improve services in the future.

5.3 Wiltshire Police

- The Police have found in comparison to current standards and policies in addressing issues of reported domestic abuse there were historic failures in dealing with the reported incidents of domestic abuse committed by a then serving police officer. It is recognised that there have been major procedural and policy changes since that time which, if adhered to, should ensure this would not occur now.
- The Police/BMA protocol whereby letters are sent from the Police Licensing Department to GPs to enquire if there are any concerns regarding a patient holding a firearm/shotgun licence needs to be reviewed as there is currently no requirement for the GP to keep a record that a patient has access to firearms. This case highlights that GPs can have pertinent information available to them which may indicate to the Police that a firearm/shotgun licence should be revoked at least temporarily.

Section Six: Conclusions

6.1. In reaching their conclusions the panel has focused on the questions:

Have the agencies involved in the DHR used the opportunity to review their contacts with Mrs A and Mr B in line with the Terms of Reference (ToR) of the review and to openly identify and address lessons learnt?
Will the actions they take improve the safety of domestic abuse victims in the County in the future?
Were the deaths predictable?
Could they have been prevented?

The review panel commends the manner in which organisations have used their participation in the review, to not merely identify and address lessons learnt from their contacts with Mrs A and Mr B in line with the Terms of Reference but have gone beyond the ToR requirements to take action on other issues of concern.

6.2 The police response to the reports by Mr B's wife of incidences of physical violence in 1998 was inadequate; however the review panel acknowledges that since then, the Police have introduced clear and robust domestic abuse policies, procedures and training, which are regularly reviewed. These will, if properly implemented, improve the safety of domestic abuse victims in the County in the future.

6.3 The current protocol whereby the Police Licensing Department write to GPs asking if there is any cause for concern that a patient has been issued with or renewed his/her firearm certificate; includes a paragraph, that if there are no concerns the GP can destroy the letter. This means that if at a later time the patient suffers an illness, which would give raise concerns about the safety to himself or another person, the GP will have no record that he/she has access to firearms. Whilst this should be addressed at a national level, the Police Licensing Department and local GP Practices' pilot programme, introduced as a result of this Review, should, in County, reduce the dangers associated with people suffering from mental health issues having access to firearms and shotguns. The chair of the national Firearms & Explosives Licensing Working Group supports the aims of the pilot and has asked to be sent a copy of a report on the programme in due course.

6.4 The review panel after considering all of the information provided does not believe that the deaths were predictable nor could they have been prevented. Mr B had told his GP and counsellor that he was not suicidal and "could not do that to his boys". Mrs A had taken what she believed to be the only keys to

his firearms cabinet but he still found a way. Questions have been raised regarding the possible side effects of combining the different medications Mr B was given over a short period of time but Mr B's GP who had known him for many years was treating him to the best of his ability in the light of information then available to him. A consultant psychiatrist consulted by the Review on this issue is of the opinion that "if the doses of these medications were taken as specified, then they probably helped reduce insomnia and anxiety".

6.5 Mr B had been violent to his ex-wife in the past and had according to friends and family, over the past few years of his life regularly been abusive towards Mrs A. He did not approve of her continued friendship with Mr & Mrs P, with whom he had fallen out and he was upset she was taking her mother to see them on the day he killed her.

His work performance in some areas was viewed as below the required standard and his line manager raised this with him.

He had been particularly close to his mother who has died two years previously and a recent visit to family in Australia, who he had last visited with his mother, brought her death back to him.

For whatever reason, during the last weeks of his life he was suffering from insomnia and depression and it will be for the Coroner's Inquest to consider why Mr B shot Mrs A and then himself.

Section Seven: Recommendations

7.1 Wiltshire Police and NHS Wiltshire have jointly recommended that:-

- The last paragraph in the standard letter sent to the GP of a firearms licence holder by the police licensing department should be removed. (See letter in Appendix H). Whilst this is a national issue which has been brought to the attention of the Coroner and the Chair of the national Firearms and Explosives Licensing Working Group, Police Licensing Department will leave out this paragraph during the period of a local pilot programme.

- A protocol will be established between Wiltshire Police and NHS Wiltshire on behalf of GPs that patient records are flagged that they hold a firearm licence and that the Police are informed if a GP has safety concerns relating to a patient with access to firearms. The protocol should direct what should be done in cases of emergency. The National Firearms and Explosives Working Group will be asked to consider these recommendations at a national level.

7.2 NHS Wiltshire CCG has recommended separately:-

- That there will be a high level case summary to local GPs relating to firearm licence holders, with appropriate information being shared with the "Out of Hours" service (OOH).

- The requirements of Mental Health Act Section 13.4 will be included in local GP training.

- An update of GP guidance re Domestic Abuse will be completed.

- An external review of the prescriptions provided to Mr B between 12th February 2013 and 2nd March 2013 will be completed with feedback being given to the individual practice involved.