FDCNH/14

Domestic Homicide Review

Executive Summary

Ms G - Born: January 1987 - Died: May 2014

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Independent Overview Author

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DHR – FDCNH/14

1. Introduction

1.1 This Domestic Homicide Review examines the circumstances surrounding the sudden and unexpected death of Ms G in Derbyshire in 2014. The Police and ambulance were contacted reporting that a women was suffering from stab wounds and that her partner Mr F was responsible. He was at the scene administering first aid to Ms G. Sadly Ms G died as the result of the stab wound to her abdomen. Mr F was initially charged with her murder but admitted to and was convicted of her manslaughter and sentenced to six years imprisonment. Those involved in the review would like to express their sympathy for the family and friends of the victim for their sad loss in such tragic circumstances.

2 The Review Process

2.1 This summary outlines the process undertaken by Derbyshire Domestic Homicide Review Panel concerned in reviewing the death of Ms G. The Panel was convened by Derbyshire Community Safety Partnership. Mr F her partner was convicted of her manslaughter in October 2014 and was sentenced to six years imprisonment.

2.2 The process began with an initial meeting on the 9th July 2014 of all agencies that potentially had contact with Mr F and Ms G prior to the point of her death. The process followed the Multi-agency Statutory Guidelines for the conduct of a Domestic Homicide Review 2011.

2.3 Agencies participating in this case review are:

- Derbyshire Constabulary
- Crown Prosecution Service
- Derbyshire County Council – Children and Younger Adults
- Derbyshire County Council – Domestic Abuse Commissioning Services
- East Midlands Housing (emh)
- NHS Southern Derbyshire and Erewash Clinical Commissioning Group.

The Panel would like to thank the family of Ms G and of Mr F for their involvement in this review. Mr F was also interviewed for the purpose of his contribution to the process. An independent Chair Person and an independent Report Author were appointed to the Review Panel to ensure the impartiality of the review.

2.4 In line with the Terms of Reference the Domestic Homicide Review has covered in detail the period identified as being in scope which was from January 2012 to May 2014, covering the length of time of Ms G and Mr F's relationship, which ended in her death in May 2014. To enable greater understanding of the case and the lessons to be learned where there was relevant information outside the scope period this was shared with the Panel. Each agency report included:

- A chronology of involvement with Ms G and Mr F, what the contact was, what was agreed and what actions were taken.
- Individual Management Reviews considered analysis of involvement, effective practice, whether internal procedures were followed and conclusions and recommendations from an agency perspective.

3. Terms of Reference

3.1 The purpose of the review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the ways in which local professionals and organisations work individually and together to safeguard victims.
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted upon, and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate.
- Prevent domestic homicide and improve service responses for all domestic abuse victims and their children through improved intra and inter agency working.

4. Key issues arising from the review and lessons learned

4.1 There was evidence that the Police investigation lacked the use of probing and exploratory questions to gather information to ensure a robust risk assessment e.g. on the 2nd June 2013 following an incident that was reported to the police Ms G initially said she had been punched first , the presenting issue of her as the abuser was accepted, also despite the fact she had a broken ankle which she said had been caused by falling over a child's cycle in the hallway, there was no information included in the Domestic Abuse Stalking and Honour based violence crime form concerning children at the address. The response of 'no children' was accepted at face value rather than further questions being asked to clarify why there was a child's bicycle in the hall.

4.2 Similarly hospital staff did not explore the discrepancies in the story provided as to how the broken ankle was caused in order to complete a full assessment.

4.3 Whilst Mr F disclosed to the General Practitioner relationship difficulties, there is no evidence that the possibility of domestic abuse was considered or explored. Where relationship difficulties are disclosed it may assist further disclosure if the health providers applied professional curiosity in an attempt to diagnose and provide preventative and safety information.

4.4 The completion of and the quality of the Domestic Abuse Stalking and Honour based violence crime form risk assessments were inconsistent e.g. both Ms G and Mr F were considered victims of domestic abuse following an incident in September 2012. However there was only one form completed regarding Ms G. Best practice would indicate two forms should be completed then information from the second form concerning Mr F as the victim could have provided useful intelligence for any future incident. Whilst the incident of the 13th April 2014 was considered to be domestic abuse by the attending Officer the Domestic Abuse Stalking and Honour based violence crime form was not completed the incident being signed off as drunk and disorderly anti-social behaviour. Had the Domestic Abuse Stalking and Honour based violence crime form been completed, the incident would have then been dealt with under the repeat domestic violence perpetrator management plan and may have been subject to proactive targeting.

4.5 Information sharing and communication between the Police and hospital staff when Ms G was taken to Accident & Emergency with a broken ankle was lacking and the domestic abuse known about by Police was not disclosed. Police did not provide information and hospital staff did not question Police attendance with Ms G. It is important information is shared in order to provide a consistent approach in applying

domestic abuse policies and to ensure all assessments are based on full information and a complete social history.

4.6 The use of alcohol with both parties drinking to excess may have complicated Police assessments and distracted from the recognition of a pattern of domestic abuse that was emerging. Alcohol use increases the occurrence and severity of domestic abuse but should be excluded as a mitigating factor for violent acts. It is important that we continue to raise awareness of the links between alcohol use and domestic abuse and ensure closer working together of domestic abuse and alcohol support services at every opportunity.

4.7 The first incident of domestic abuse in September 2012 was dealt with by way of Restorative Justice. In 2013 Her Majesty's Inspector of Constabulary recommended 'the Force should consider the appropriateness of using restorative justice for offences in intimate relationships particularly with regard to how any action will prevent further offences of domestic abuse or reduce the risk to the victim'. Following this recommendation Derbyshire Constabulary appropriately withdrew the use of restorative justice in all intimate partner related domestic violence crimes with effect from 1st April 2014.

4.8 The quality of recording by hospital staff was variable in terms of accuracy and in identifying who was responsible for the entry. A reminder of the importance of quality recording would be beneficial.

5. Conclusion

5.1 Ms G and Mr F had been in an intimate relationship for a little over two years when she died. A verdict of manslaughter was given in October 2014 with Mr F being sentenced to six years imprisonment for her killing.

5.2 There was very little agency involvement with the couple, contact being recorded with the Police, hospital and the General Practitioner. The Police were aware and had identified three domestic abuse incidents including September 2012, June 2013 and April 2014. No other agency had recognised or were aware of domestic abuse in the relationship neither had Ms G nor Mr F disclosed to professionals other than the Police that domestic abuse was a feature of their relationship. They had not sought assistance from any domestic abuse support agency.

5.3 Both Ms G and Mr F were recorded as both the perpetrator and victim of domestic abuse. There were no prosecutions against either for domestic crime. Members of the public, a neighbour and the town centre close circuit television footage had reported abusive events. Both partners were reticent to make complaints and wished to understate abuse apparently not recognising it as a feature of their relationship. In June 2013 although Ms G was seen as the aggressor by Police following information given by the couple, it may be that with the benefit of hindsight this was inaccurate and Ms G's ankle injury was perhaps the result of Mr F pushing her over. It would appear physical abuse would follow arguments where the couple were both drunk and where Mr F may have goaded Ms G to get a response. e.g. There is evidence from the family that they witnessed Mr F using verbal abuse to undermine and embarrass Ms G in public and Ms G told her mother of other occasions where Mr F wrongly accused her of having relationships with other men.

5.4 Alcohol abuse would appear to have played an important role in the relationship and both Mr F and Ms G drank to excess on occasions. The domestic abuse that came to the attention of the Police followed drinking bouts. It is recognised that alcohol can distract from the issue of domestic abuse and it should be recognised that alcohol use increases the occurrence and severity of domestic abuse but is not the cause and should be excluded as a mitigating factor.

5.5 [Redacted] Whilst Mr F disclosed that he was unhappy in his relationship neither Ms G nor Mr F disclosed domestic abuse to the General Practitioner. Domestic abuse was not explored as a possible feature in their lives that could have led to the feelings of low self- esteem and helplessness often associated with depression.

5.6 Although Mr F did not have custody of his [Redacted] children from previous relationships he did have regular contact at weekends. Whilst Ms G had her own independent accommodation the couple spent most of their time together at Mr F's flat. The involvement of children and the possible impact upon them of the abuse was not identified by Police and there was no liaison with Social Care. The Think Family agenda promotes the importance of a whole family approach. It is crucial in domestic abuse circumstances that the implication on family and in particular children is considered by all agencies involved in service delivery. There had been previous incidents of domestic abuse where Mr F was the perpetrator in 2002 however processes were different at that time and he was not charged or convicted of a domestic abuse offence and as a result this information was not used to assess his recent behaviour.

5.7 The lessons learned identify areas for improvement that have come to light during the preparation of this review. Neither party disclosed the domestic abuse in their relationship as it would appear neither recognised it in those terms. This review explores some of the possible reasons for this. The domestic abuse that was reported to and assessed by the Police would appear appropriately classified as standard risk and therefore, in line with policy, would not require referral for multi-agency assessment. The domestic abuse was seen as low level alcohol fuelled and as a result Ms G's death was neither anticipated nor therefore considered predictable given the information that was available.

6. Relevant changes in policy and practice already made by Agencies since the domestic abuse incidents occurred and before the review was finalised

Derbyshire Constabulary

6.1 In December 2014 Derbyshire Constabulary introduced a Domestic Violence Scrutiny Panel which assesses the quality of domestic abuse assessments and shares good practice and any learning points across the force.

6.2 During 2014 Derbyshire Constabulary have introduced a Serial and Repeat Domestic Violence Perpetrator Management Plan. A monthly list of serial and repeat perpetrators is recorded on the Guardian Intelligence system database. Those on the list are then prioritised and those considered at greatest risk are subject of a tasking process.

6.3 Since June 2014 a Domestic Violence Investigative Toolkit has been created which Officers use as a template for their investigation. This includes detailed information on how best to investigate domestic abuse incidents, provides information regarding the key objectives of prevention, intelligence gathering and enforcement. It has a 'built in'

information log recording any activity against the perpetrator. There is also an action plan which records the date an action was raised through to its completion. There actions incorporate legislation introduced in June 2014 concerning Domestic Violence Protection Notices and Domestic Violence Protection Order scheme which provides an alternative method of dealing with ongoing domestic related issues.

6.4 As from the 1st April 2014 Derbyshire Constabulary have withdrawn the facility to use restorative justice to resolve intimate partner related domestic violence crime.

6.5 Following the inspection by Her Majesty's Inspector of Constabularys, all domestic abuse incidents are now subject of a quality check by the attending Officer's Sergeant. Also the Command and Control incident cannot be closed until this has been completed. This came into force in January 2014.

6.6 One of the questions to be answered by the Sergeant's quality assurance is about the recording of full details of all children connected with all parties/household and whether a referral to Children's Social Care is requested. This process will be updated in January 2015.

6.7 From January 2015 every domestic abuse incident investigated by the Police where children are involved is referred to Social Care, Education and Health for consideration. This process is awaiting ratification.

6.8 All front line staff who are likely to be involved with domestic abuse cases are undergoing refresher training; this is already showing improvements in the quality of the DASH forms submitted by attending Officers.

7. Recommendations

Derbyshire Constabulary

7.1 Where both parties in an intimate relationship assault each other and appear equally to be responsible for the incident, best practice would be to submit two Domestic Abuse Stalking and Honour based violence crime forms. Although the submission of a second form may seem bureaucratic it identified both parties as perpetrators and victims of domestic abuse which may prove useful when conducting future risk assessment on those individuals. Derbyshire Constabulary should include guidance relating to this issue within their Domestic Violence Investigation Toolkit.

7.2 Police Officers investigating domestic abuse incidents should be reminded of the importance of using exploratory and probing questions to gather information. It is important to ensure underlying issues are considered when making a full assessment of the situation and to guard against presenting issues being accepted at face value. It is recognised that many victims have to overcome several barriers before they are able to disclose abuse.

7.3 In line with the Think Family agenda Police Officers should be reminded of their duties in relation to safeguarding children when attending incidents of domestic abuse. Full details of children including other family names and addresses should be obtained. Officers should also engage with any children present at the address in order to comment upon their demeanour. When Officers do not see children they should look for signs of children such as toys, clothing etc. Positive action should be taken to safeguard

children and where there are concerns as to their welfare then referrals should be made to Social Care.

7.4 If there is a history of domestic abuse linked to alcohol abuse or excessive alcohol consumption consideration should be given to referrals to alcohol support agencies as well as domestic abuse services. Perpetrators arrested for domestic abuse should be actively encouraged to engage with substance misuse staff based within the custody suite.

NHS Southern Derbyshire and Erewash Clinical Commissioning Groups

7.5 Remind hospital staff of the importance of accurate and timely recording to ensure relevant information is available to underpin a full and holistic assessment.

7.6 Remind health staff, including GPs, of the importance of using professional curiosity and probing questions when relationship issues are disclosed.

7.7 Remind GPs of the significant indicators of domestic abuse that increase risk, including relationship breakdown and the use of alcohol and drugs and the importance of information sharing and referral on to specialist domestic abuse services.

NHS and Police

7.8 Review and clarify the information sharing protocol in relation to Police providing information to hospital staff about domestic abuse where Police accompany an individual to Accident & Emergency department following an incident. Confirm what National Health staff should do in order to gather this information where it is not forthcoming.

Community Safety Partnership

7.9 Promote greater awareness of the links between alcohol abuse and domestic abuse and work towards excluding alcohol as a mitigating factor for violent acts. Promote closer working together of domestic abuse and alcohol support services.

7.10 Share the anonymised conclusions and learning from this review with other partners to remind agencies of the importance of recognising and intervening in domestic abuse cases in an attempt to protect the victim.

7.11 Continue to consider how the barriers to disclosure of domestic abuse can be overcome for victims, perpetrators and staff to improve practice and prevention of ongoing abuse.

Multi-Agency

7.12 Domestic Violence/Sexual Violence Governance Board to seek an update on the IRIS

(Identification and Referral to Improve Safety) programme running as a pilot in one area of Derbyshire and consider how to take forward the outcomes to improve the GP's role in identifying and responding to domestic abuse and in sharing relevant information with other key agencies to improve safety.

Marion Wright