DOMESTIC HOMICIDE REVIEW CASE 2:

EXECUTIVE SUMMARY

DECEMBER 2012

Safer Devon Partnership

INTRODUCTION

1. This report of a domestic homicide review (DHR) examines agency responses and support given to Subject A, a resident of Exeter, and her family, prior to her death in July 2011. The review considers agencies' involvement from 2002 onwards with Subject A and with Subject B, her long term partner, who has been convicted of her manslaughter. It was conducted by the Safer Devon Partnership, on behalf of Exeter Community Safety Partnership.
2. The key purpose for undertaking DHRs is to enable lessons to be learned where a person is killed as a result of domestic violence. In order for these lessons to be applied as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.
3. The review was conducted by a panel with an independent chair and representatives of :
    - Devon County Council
    - Exeter City Council
    - Devon & Cornwall Police
    - NHS Devon
    - Royal Devon & Exeter NHS Foundation Trust
    - ADVA (Against Domestic Violence and Abuse).
4. The review report draws on information and analysis from the agencies which were potential support agencies for Subject A prior to her death. A number of local agencies checked their past contacts with Subject A and her household. Relevant records of involvement were identified by the County Council, police and health services.

5. The review started in September 2011, setting terms of reference in the light of a joint chronology of contact with the family. The preparation of individual management reviews (IMRs) by agencies was deferred until criminal proceedings were completed in December 2011. IMRs were requested from Devon & Cornwall Police, Devon County Council, Royal Devon and Exeter NHS Foundation Trust and Northern Devon Healthcare Trust. The panel drew up an overview report based on these, other information about local services and a conversation with a family member. The overview report is available to the agencies responsible for responding to domestic abuse. The review completed, within the target timescale of six months from the end of the court case, in June 2012.

CIRCUMSTANCES OF THE HOMICIDE

6. On 4th July 2011 Subject A took an overseas holiday. She did not tell Subject B that she was going on holiday, and he became distressed and concerned. They are thought by family to have met and talked on her return from the holiday on 12th July.

7. During the afternoon of 14th July Subject A and Subject B were seen by neighbours jointly preparing for a barbecue at the house. At around 7pm that evening, Subject B killed Subject A in the kitchen, in the course of a fight in which he received minor injuries. There were no witnesses, but the police investigation found no evidence of premeditation, and the prosecution accepted his plea of manslaughter by loss of control. According to Subject A, the fight started when Subject A started drinking and he challenged her and poured it away. He also testified that she was the first to pick up the kitchen knife with which he subsequently stabbed her 19 times. The testimony of the perpetrator, as given to the Court, was supported by Police forensic evidence, and was accepted as a record of what happened.

CONCLUSIONS AND RECOMMENDATIONS

Was there a record of domestic abuse?

8. The first incident of domestic abuse by Subject B against Subject A recorded by police was nine years before the homicide, in 2002. During these years there was no full multi-agency assessment of the family as a whole or of the risk to Subject A. Broadly speaking, agencies played separate roles.

    a) The police responded to domestic abuse incidents as well as anti-social behaviour and other incidents involving the household, tracking domestic abuse on a risk scale and investigating possible crimes.

    b) Devon County Council Children's and Young People's Service (CYPS) looked at the behaviour of and risks to the children during their teenage years, receiving information from the police about domestic abuse as context for this, and alerting police to allegations of crime. They undertook a joint investigation with police in 2008, assessing the risk to Subject D (a child of Subject A and B), but found this below the threshold for statutory intervention.

    c) NHS primary care and hospital services treated Subject A's physical health, aware of her alcohol misuse but not of domestic abuse.

Could the homicide have been predicted or prevented?

9. The homicide could not have been predicted by public agencies, or prevented by action at the time. It occurred three months after the last domestic abuse call to police, which had been risk assessed as not indicating the likelihood of serious harm – matching the family view. While there had been repeated domestic abuse over the previous nine years, including clustered incidents, the level had not escalated. Subject B had no previous convictions for violent crime, and no known mental illness. On the evening of the homicide the couple were together, with no other parties present, and no emergency calls were made until after Subject A's death. The court judgement, taking account of forensic evidence and Subject B's testimony, was manslaughter due to loss of control.

10. We will never know whether this homicide could have been prevented by earlier interventions, however, there are lessons that can be learned. With the right sort of help in earlier years, it is possible that the relationship would have taken a different turn, avoiding the homicide. This review has identified points at which the response provided by agencies was in line with policy at the time, but not with what is now regarded as good practice. Decisions were made which were reasonable with the information available, but missed opportunities for a more substantial offer of support to Subject A. Although some opportunities to help were missed by public agencies, Subject A appeared unwilling to engage when offers were made, so it is not possible to say whether the outcome would have been different.

What can be learned to improve future practice?

11. Throughout this period Devon had a strategic approach to tackling domestic abuse, implemented through a multi-agency partnership which reviewed and expanded its approach. Agencies had policies, procedures and training in place, which developed and improved over time. So far as can be judged from the records, staff followed practice expected at the time in their dealings with Subject A, but there was an unexplained loss of information during transfer between agencies. Subject A was given information about self-referral services and helplines covering Exeter, and was in contact with her solicitor, but chose not to seek advice from other agencies, although she was confident in approaching public agencies on other issues. There was a well-established MARAC and IDVA service coordinating support for victims judged at greatest risk. However, the process in place at the time meant that this case was not referred to MARAC: the capacity of services available played a part in this during 2009, affecting the selection of non-crime cases for the MARAC, the time lapse in CYPS review of police 121as, and the persistence of Domestic Abuse Officers (DAOs) in seeking to establish contact with Subject A.

12. The story of Subject A illustrates the scope for taking a cumulative view of the problems within a family even when individual incidents are below the threshold for intervention. A number of professionals from different agencies had contact with them over recent years, each seeing only part of the picture and focused on making a correct response to the presenting

incident. The question of “Why is this happening?” was rarely explored. The public services that Subject A saw most frequently and voluntarily – her GP practice and her children’s school - did not see the domestic abuse. Subject A’s misuse of alcohol was widely known, but regarded as a complicating factor rather than as a potential symptom of deeper problems. There will always be a limit to the capacity for full multi-agency review and support through MARAC, and the family did not have the level of multiple problems that would trigger a “family support” scheme under current guidance. The challenge for agencies is, within the legal constraints on sharing information, to take a holistic approach so that all contacts contribute to reducing the underlying risk.

13. Devon’s systems for dealing with domestic abuse have improved in recent years, and the arrangements now in place address many of the lessons from this case. There is a more robust risk assessment tool for domestic abuse, more signposting of advice at hospital, better coordination of the response where young people are in the household, and increased capacity to treat alcohol misuse. However, there is still much to be done to ensure that all professionals in contact with families in difficulty recognise their role in identifying and responding to domestic abuse and alcohol misuse.

RECOMMENDATIONS

- **R1. Encourage an approach to assessment that explores the background to low self-esteem, a particular form of damaging behaviour or lifestyle rather than just treating the symptoms, and ensure that records are kept to show where this has taken place.**

- **R2. Find appropriate ways to share the results of domestic abuse risk assessments with agencies engaged with the family, even where the risk does not lead to a MARAC referral.**

- **R3. Ensure effective provision of information to, and transmission of referrals from, the Police and the Multi Agency Safeguarding Hub (MASH) and that there is an auditable system to check that referrals are received by third parties**

- **R4. Ensure all agencies know what a DASH risk assessment is, and how and when to use it in households where there is domestic violence and abuse.**

- **R5. Improve the awareness of and response to domestic abuse by GP practices.**

- **R6.Improve hospital staff awareness of and ability to respond to domestic abuse.**

- **R7. Ask relevant patients about abuse when they attend hospital.**

- **R8.Implement further training and initiatives to improve the response by all agencies to alcohol misuse in line with the Devon alcohol strategy.**