BIRMINGHAM COMMUNITY
SAFETY PARTNERSHIP
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Domestic Homicide Review

Executive Summary of the report into the death of a woman

BDHR2012/13-02

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Presented to Birmingham Community Safety Partnership on 9th May 2013

INTRODUCTION

The purpose of this domestic homicide review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way 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 on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to the policies and procedures as appropriate; and
- Prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working

A domestic homicide review is not an inquiry into how a victim dies or into who is culpable as those matters are for Coroners and criminal courts to determine. Domestic homicide reviews are not specifically part of any disciplinary enquiry or process. Where information emerges during the course of a domestic homicide review which indicates that disciplinary action should be initiated then the relevant agency disciplinary procedures should be undertaken separately to the domestic homicide review process.

In production of this report, agencies have collated sensitive and personal information under conditions of strict confidentiality. The Birmingham Community Safety Partnership has balanced the need to maintain the privacy of the family with the need for agencies to learn lessons relating to practice identified by the case and has authorized the publication of sufficient information to enable this to take place.

A decision to undertake a domestic homicide review was made on the 3 June 2012. The Birmingham Community Safety Partnership determined that agencies would secure and review

their files from 2008 until the date of the victim's death. Agencies were required to compile an Individual Management Review to provide an independent, open and critical analysis of individual and organisational practice. The Individual Management Reviews identify lessons learnt by the individual agencies, highlight any good practice and include recommendations for single agencies to improve practice.

Terms of Reference

In addition to the generic terms of reference contained within the *Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Home Office 2011),* the following specific issues were to be addressed by the General Practitioner:

- *All aspects of care and treatment of mental health issues in respect of the alleged perpetrator and the victim.*

- *Whether there were any safeguarding issues in respect of the victim, or others, and whether these were appropriately managed.*

- *Whether the assessment of risk was appropriate and adequate in the light of recent presentations and previous clinical history.*

SYNOPSIS

In the early hours of 8 May 2012, a telephone call was received by Ambulance control from the husband (alleged perpetrator) of the victim who stated that his wife had been choked at their home address. The police were informed and upon arrival at the home address police officers had to force entry into the property as it was found secure and in darkness. The officers found the alleged perpetrator slumped on the stairs supported by a ligature tied around his neck from the top banister post. He was unconscious, had a weak pulse and was immediately taken to hospital. The body of the victim was found in the main bedroom and efforts to resuscitate her proved unsuccessful. A post mortem took place and the cause of death of the victim was found to be strangulation. Indications from the injuries sustained by the victim are that a struggle had taken place before her death. The police have been unable to question the alleged perpetrator about the events leading up the death of his wife as he has sustained a severe hypoxic brain

injury and required constant nursing supervision and was unable to communicate until his own death later in 2013.

The victim and her husband were married for 36 years and it is evident from the findings of the domestic homicide review and from the police investigation that there is no indication of an abusive or violent relationship between them. They had two children who are now adults and whilst they were living away from the family home at the time of the incident, the family unit maintained close and regular contact. It is evident that this was a close knit family who also resided near to extended family members. The family were to experience a difficult period after the bereavements of close elderly family relatives and from that time the alleged perpetrator began to show signs of stress and depression.

The only agencies involved with the victim and her husband were from Health: primarily their GP Practice, plus a short term Counselling Service provided to the alleged perpetrator by his employers. Whilst the victim was an infrequent visitor to the GP Practice, her husband was a frequent visitor. The majority of these visits related to physical ailments for which he was also referred to specialist services for investigations and treatment at hospitals. He underwent a hip replacement operation in August 2011 but when he returned to work, his behaviour and personality seemed to change. It is clear that a rapid deterioration in the alleged perpetrator's mental health followed. In February 2012 he visited his GP and reported being depressed about bereavements, problems at work and he displayed introspective and anxiousness symptoms. He was seen a further seven times at the GP practice in connection with his depression and was prescribed anti- depressant medication. He was signed off work from 1 March 2012 and referred himself for a course of short term counselling which was provided by his employer.

FAMILY AND ASSOCIATES ENGAGEMENT

The adult children and a family friend who was also a work colleague of the victim contributed to this domestic homicide review providing information which greatly assisted the findings, learning and conclusion.

LEARNING

Key Issues:

- **Ability of family to engage with GPs**

Despite attempts by the victim and the children they were unable to engage with the GPs about their concerns of the mental health of the alleged perpetrator. The family had no experience of mental health problems and would have benefitted from help and guidance of how to provide support and of how to cope with the behaviour of the alleged perpetrator.

- **Primary and secondary mental health services**

The alleged perpetrator only received primary care for his mental health problems. The GPs were reliant upon information disclosed by the alleged perpetrator and it is likely that they were unaware of the full extent and rapid deterioration of his mental health and of his increasing paranoia. A referral for secondary mental health services was not made although it was decided at the alleged perpetrator's last visit to the GP that he was at the stage where this was appropriate.

- **Assessment & Management of risk**

The alleged perpetrator was never subject of a formal risk assessment tool but both the GP and the counselling service utilised a questionnaire, and in both cases these questionnaires aided the assessments made by the professionals involved. Indications from both were that the alleged perpetrator presented a risk of self-harm but not a risk of harm to others.

- **Ancillary Issues**

There is no evidence or any indication that domestic abuse was a factor in the relationship between the victim and the alleged perpetrator. However, it was found during this review that the GP practice did not have a standalone policy on domestic abuse, staff had not received training and there was no identified lead and no formal pathway for responding to disclosure in respect of domestic abuse.

Lessons Learnt

- The family was inexperienced in dealing with mental health problems and found it difficult to engage with the GP Practice which resulted in no help or support being provided to them.
- GPs were reliant upon information gleaned from the alleged perpetrator and may have been unaware of the full extent of the increasing and rapid deterioration of his mental health and paranoia.
- GPs' recording was not sufficiently detailed to assist another GP, or a secondary mental health service, to make a mental health care assessment.
- Expectations of referral to secondary mental health services were inconsistent.
- Issues of potential self-harm were identified but the risk of harm to others appeared not to have been probed in sufficient depth.

GOOD PRACTICE

No examples of good practice over and above expected levels of service were identified during this Review.

CONCLUSION

It is concluded that the death of the victim could not have been predicted. However there is a possibility that it could have been prevented had the alleged perpetrator been subject of a mental health assessment together with more robust treatment of his depression.

DOMESTIC HOMICIDE REVIEW PANEL

Independent Overview Chair and Author: Gill Baker O.B.E.

Panel Members:

- Senior Service Manager for Violence Against Women – Birmingham Community Safety Partnership
- Designated Nurse – Safeguarding Adults and Children and Mental Capacity Act Lead for Solihull Clinical Commissioning Group (formerly Head of Safeguarding Adults & Children, Birmingham and Solihull NHS Cluster)
- Operations Manager - Birmingham & Solihull Women's Aid
- Safeguarding Lead, Women, Domestic Violence & Sexual Safety - Birmingham & Solihull Mental Health Foundation Trust.

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DOMESTIC HOMICIDE REVIEW OVERVIEW RECOMMENDATIONS

- NHS England Birmingham, Solihull and Black Country Area Team to work with key stakeholders (including Health Education England and local Clinical Commissioning Groups) to ensure that all frontline health professionals have access to good quality healthcare information about mental health and psychological interventions that will assist them to better support patients and their families and signpost them to the relevant, available support where appropriate.

- Birmingham Community Safety Partnership requires all recommendations contained in agencies Individual Management Reviews to be fully implemented. In addition, agencies are required to confirm that action has been taken where management or practice has fallen below expected standards of professional behaviour.

SINGLE AGENCY RECOMMENDATIONS

- The GP practice provide a more robust referral process and threshold for referral to secondary health services to ensure that patients receive prompt initial assessment and appropriate treatment.

- The GP practice ensure that patient records include full details of incidents and behaviour disclosed when a patient has indicated or been assessed as posing a risk of harm to self or to others

- The GP practice improve the quality and consistency of responses to domestic violence and safeguarding adults

- The counselling service strengthens their risk assessment processes and recording practices to ensure that potential risk of harm to others are fully explored and referral for specialist services actioned