# EXECUTIVE SUMMARY

# DOMESTIC HOMICIDE REVIEW

**in respect of**

# A

**Born 1969**

**Sue Lane**
**October 2014**

**Moorlands Together Safer and Stronger Communities Partnership**
**Moorlands House Stockwell Street Leek ST13 6HQ**

# 1 Introduction

## 1.1 Context of the Domestic Homicide Review

1.1.1 Domestic Homicide Reviews were introduced by the Domestic Violence, Crime and Victims Act (2004), section 9.

1.1.2 A duty on a relevant Community Safety Partnership to undertake Domestic Homicide Reviews, along with associated procedural requirements, was implemented by the *'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews'* in April 2011[1]. This defined a Domestic Homicide Review[2] (DHR) as:

a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

- a person to whom he was related or with whom he was or had been in an intimate personal relationship; or
- a member of the same household as himself

held with a view to identifying the lessons to be learnt from the death.

1.1.3 The purpose of a DHR 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 policies and procedures as appropriate; and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

1.1.4 DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for Coroners and criminal courts. They are also not specifically part of any disciplinary enquiry or process; or part of the process for managing operational responses to the safeguarding or other needs of individuals. These are the

[1] www.homeoffice.gov.uk. The statutory guidance was revised in August 2013.
[2] Domestic Violence, Crime and Victims Act (2004) section 9 (1).

responsibility of agencies working within existing policies and procedural frameworks.

## 1.2 Circumstances of the review

1.2.1 A was found dead as a result of stab wounds in January 2012 at the home he shared with his partner B. She too was found dead on the premises. The alarm was raised by the family of B who had called round as they could not get an answer to telephone calls. Police enquiries rapidly established that A had been killed and that B had committed suicide and that no other person was involved.

1.2.2 The location of these events is a small community within Staffordshire Moorlands District. The individuals involved were born and brought up in the area and their families lived close by and continue to do so. The events deeply shocked and surprised the families, the community and the professionals who knew the couple.

## 1.3 Terms of reference

1.3.1 A DHR Scoping Panel met on 6 February 2012 to consider the circumstances leading to the death of A. The Panel was unanimous that the criteria for commissioning a DHR had been met. This recommendation was endorsed by the Chair of the Moorlands Community Safety Partnership (CSP) who was present at the meeting and the decision was recorded. Full terms of reference for this DHR are attached at Appendix A.

1.3.2 The DHR considered the period from 5 October 2007, when B seriously harmed herself (the last occasion on which she did so before her death), up to and including the date of A's and B's deaths in January 2012. The focus of the DHR was maintained on the following family members:

| **Name** | **A** | **B** |
|---|---|---|
| **Relationship** | Subject of DHR | Partner |
| **Date of Birth** | Aged 42 | Aged 46 |
| **Date of Death** | January 2012 | January 2012 |
| **Ethnicity** | White British | White British |

1.3.3 Key issues addressed by the DHR, in the context of the general areas for consideration listed at Appendix 1 of the Statutory Guidance, are outlined below.

- Were any risks posed by B to her partner identified by any agency and appropriately understood/shared/acted upon?

- Were any concerns for his personal safety expressed by A or recognised, appropriately risk assessed and responded to?

- Should B have been identified as a risk to herself and others in the period under review?

- Provision of mental health services to B.

- The significance of both A and B acting as carers for each other with their very different health problems.

- Specific equality and diversity issues such as ethnicity, age, disability or vulnerability that require special consideration.

- Was the homicide of A predictable and/or preventable?

1.3.4 It has not been necessary to amend the terms of reference in the course of the review.

## 1.4 Contributors

1.4.1 Individual Management Reviews (IMRs) were provided by the following agencies which had contact with A and/or B during the period under review:

- University Hospital North Staffordshire NHS Trust
- North Staffordshire Combined Healthcare NHS Trust
- Staffordshire NHS Trust Cluster of PCTs
- Staffordshire Police
- Staffordshire Moorlands District Council

A summary report was provided by West Midlands and Staffordshire Probation Trust regarding their involvement with B prior to the review period.

1.4.2 All agencies submitted chronologies and IMRs as requested. The Panel is satisfied that these are comprehensive reports and that they make appropriate recommendations for their agencies where necessary. No other agencies have been identified as having had involvement with A or B as a result of the IMRs.

## 1.5 DHR Panel members

| Agency | Job Title |
|---|---|
| Independent Chair | Independent Chair |
| NHS Staffordshire Commissioning Support Services | Designated Nurse Child Protection |
| NHS Staffordshire Commissioning Support Services | Lead Nurse Adult Safeguarding (North Staffordshire) |
| North Staffordshire Combined Healthcare NHS Trust | Team Leader Criminal Justice Mental Health Team |
| Staffordshire County Council - Adult Safeguarding | County Commissioner Adult Safeguarding |
| Staffordshire County Council - Community Safety | Principal Community Safety Officer |
| Staffordshire County Council - Community Safety | County Commissioner for Safer Communities |
| Staffordshire Moorlands District Council | Community Safety Manager |
| Staffordshire Police | Detective Inspector |
| Staffordshire Police | Crime and Policy Review Manager, Major Investigations Department (MID) |
| University Hospital Of North Staffordshire NHS Trust | Adult Safeguarding Nurse |

1.5.1 Arch (North Staffs), a charity which provides domestic abuse support services in the Staffordshire Moorlands District, was invited to join the DHR Panel. They were unable to attend the first Panel meeting and, as there was no indication of domestic abuse or violence ever being a feature of the relationship between A and B prior to their deaths, did not consider that their participation would add value to the subsequent meetings. It has subsequently become the practice in Staffordshire to invite the Domestic Abuse Support Services provider for the district or borough in question to fully participate in the Review Panel, regardless of whether they have had any contact with the subjects of the DHR or if domestic violence was known to have occurred.

1.5.2 The DHR Panel Chair and report author is Susan Lane. She has undertaken similar enquiries and training commissions for

safeguarding boards and is not employed by any of the agencies or associated bodies. She is an experienced and registered social worker and has previously held senior positions within children's social care and the Probation Service. She currently works part-time as an associate lecturer for the social work degree with the Open University. Following the Scoping Panel meeting it was agreed that this review did not require a separate report author.

1.5.3 The DHR Panel met on three occasions and has had the full support of the District Council and the participating agencies. The conclusion of the process was originally agreed as 6 August 2012. It was delayed until the completion of the Inquest which was held at the end of September 2012. The report was then confirmed by agencies and the families of both victim and offender were given opportunity to read the final draft before it was submitted to the CSP.

1.5.4 The Moorlands CSP approved the report for submission to the Home Office on 8 February 2013.

1.5.5 Following receipt of a letter from the Home Office dated 25 July 2013 the Panel met for the third time and the report was revised to provide more detail and analysis.

### 1.6 Parallel processes

1.6.1 No formal processes in respect of these events have been triggered other than notification to HM Coroner.

1.6.2 HM Coroner recorded a verdict of Unlawful Killing with regard to A and Suicide in relation to B in September 2012.

## 2 Family engagement

2.1.1 The Panel Chair met with the families of both the victim and the perpetrator in June 2012 to explain the process and to listen to any concerns or observations they might have. It was agreed that the draft report would be available to them shortly after the inquest. A further meeting was arranged in November 2012 when the families had the opportunity to read a final draft of the report.

2.1.2 A's family had no information which changed the findings of the review.

2.1.3 Concerns raised by B's family regarding agency practice related to:

- Their belief that B's actions were due to her mental health condition;
- That the treatment available failed her;
- That she should have been admitted to hospital in 2007.

2.1.4 The Review Panel considered these views in reviewing events. The Panel concluded that the services offered were consistent with guidance and with B's wishes regarding her treatment. There was at no time any basis for treating her against her will. There is no suggestion that any beneficial treatment was withheld.

2.1.5 When they had opportunity to view the report in November 2012 the families of B and A confirmed that the account of the facts is consistent with their experiences.

2.1.6 The Panel is grateful for their support in this difficult process.

# 3 Summary of events

3.1.1 A and B had lived together for 15 years.

3.1.2 No agency had any record of previous incidents of violence or domestic abuse in respect of either partner; either within the home or in other situations. Family members of both were also not aware of any violence or domestic abuse by B or A. Arrangements for responding to domestic abuse were therefore never triggered or tested.

3.1.3 A was well known to health agencies. He had had serious health problems from early childhood requiring regular review and substantial periods of in-patient treatment. He was booked for a further admission in January 2012.

3.1.4 The DHR looked for evidence that A had suffered any previous assaults, unexplained injuries, or evidence of coercion and bullying within the relationship. He had frequent and regular contact with health care professionals and would have had opportunities for disclosure. No unusual or unexplained injuries were ever noted from either professional records or accounts from his family.

3.1.5 Between 2002 and 2006 B was involved in disputes with neighbours and with parents of children associated with her daughter. None of these incidents resulted in either her arrest or any criminal charges. Similar events have not occurred since then.

3.1.6 B had harmed herself on at least four occasions between 1997 and 2007 but had never done so in a manner that placed A at any risk. On each occasion she accepted medication to alleviate her condition but refused social or psychological interventions. At no point had she been considered so unwell as to need formal detention in hospital and was at all times considered competent to make decisions about her own treatment.

3.1.7 The last occasion had been in October 2007 when B had inflicted wounds to her chest and neck and had thrown herself from a first floor window. She was admitted to hospital for orthopaedic treatment and assessed by mental health services.

3.1.8 Mental health services conducted full mental health and risk assessments at this time and concluded that there were continuing risks of self harm which were mitigated by the treatment provided. No risk to any other person was indicated.

3.1.9 On discharge from hospital B accepted mental health community services but within a short time was determined that out-patient attendance and her GP's support was sufficient. B was discharged from the mental health services in early 2010 by agreement. She remained on medication, supported by her GP.

3.1.10 In 2011 B reported feeling unwell and that the medication had stopped working. She refused referral back to the mental health services and sought a private consultation. This provided advice to the GP about medication which was followed. She last saw her GP in October 2011 over two months before her death, at which time she appeared 'elated'.

3.1.11 The families of both A and B report that over the Christmas period 2011, B appeared to be unwell and withdrew from the usual family gatherings. Her own family were in close touch, speaking daily to her by telephone if they did not visit. Both families also confirmed their belief that if A had had serious concerns about B or for himself in the days immediately before his death, he would have contacted them for help.

3.1.12 The bodies of A and B were discovered in January 2012 when B's family were unable to contact her by telephone, got no response at her address and called the police.

3.1.13 Forensic enquiries established that A was killed by multiple stab wounds and that B died from self-inflicted wounds to her neck. There is no evidence that A assaulted B at any point. Police enquiries were unable to discover any reason for these events and there was no suicide note. The Inquest was held in September 2012 when HM Coroner recorded a verdict of Unlawful Killing with regard to A and Suicide in relation to B.

# 4 Findings and conclusions of the DHR

4.1.1 The Panel concluded that the death of A was not predictable and accordingly not directly preventable. No professionals or family members had any information regarding, or other indication of, violence by B in the past; or that this might occur in the future. Although B's potential for suicide was known there were no

indications to professionals or family in the weeks immediately before the deaths that suggested she was contemplating suicide. It was more than two months before her death that she last had contact with her GP, when she was noted to be elated not depressed, and she had no other professional contacts in the intervening period. There were no grounds for any professional to be involved at this time on any other basis.

4.1.2 The Panel also concluded that the decisions and actions of professionals during the period reviewed were appropriate and that there were no reasonable opportunities to intervene or provide services differently which might have led to the deaths being indirectly prevented.

4.1.3 Two recommendations intended to set high practice standards for the management of those with complex health conditions in a primary care setting were made by the NHS Staffordshire Cluster of Primary Care Trusts[3]. There is no suggestion that these additional safeguards would have made any difference to the events under review but the Panel recognised that they may make a positive difference to others with complex health needs. The Panel is therefore pleased to endorse these recommendations.

4.1.4 In order to ensure that this good practice is disseminated as widely as possible the Panel recommends that NHS England promotes the use of such arrangements within primary care settings nationally. Staffordshire Moorlands Community Safety Partnership will share the findings of this review with the NHS England Shropshire and Staffordshire Local Area Team and request they take this recommendation forward in conjunction with their dissemination of the review, once published.

4.1.5 There are no other significant issues emerging from this review which require recommendations from the Panel.

[3] Responsibility for commissioning of primary care services now rests with NHS England.