Safer Devon Domestic Homicide Review

Overview Report Executive Summary
Regarding Adult B who died in August 2018

Written by:

Steve Appleton
Managing Director
Contact Consulting (Oxford) Ltd

Independent Chair and Author

July 2021

Contents

A message of condolence

The Domestic Homicide Review Panel wishes to express its condolences to the family and friends of those affected by the events described in this report. The panel hopes that the process will provide some answers to their questions.

Introduction

1. The subjects of this DHR had been in a relationship since they were teenagers. They had been together for 27 years and had two young children.

2. Domestic abuse between the couple came to the attention of agencies when it was discussed at a Multi-Agency Risk Assessment Conference in October 2017 and again in February 2018. In discussion with Adult A, she disclosed previous domestic abuse had taken place, although at the time it occurred, she did not recognise it as domestic abuse.

3. The couple were separated and in August 2018 the male subject of the review contacted his estranged wife, asking her to visit him to complete some paperwork related to the Children and Family Court Advisory and Support Service.

4. Whilst present at her estranged husbands address, the female subject of the DHR was detained against her will. She was shot in the leg with a crossbow. She was subjected to significant and sustained verbal and physical abuse over a period of many hours. This involved threats to her life, threats by Adult B to end his own life, being bound and gagged and threatened with a knife throughout an ordeal that lasted many hours. At some stage, when her estranged husband had appeared unconscious (it is not clear why), the female subject of the DHR managed to free herself and using a knife with which she herself had been threatened, stabbed her estranged husband a number of times in the neck. He subsequently died from his injuries.

5. Devon and Cornwall Police treated Adult A as a victim and gained a statement of evidence from her regarding the events of August 2018. In September 2019, following a peer review and a request by the Coroner, Adult A was questioned as a suspect in a Police and Criminal Evidence Act compliant suspect interview relating to the death of Adult B. The interview and the evidence gathered by the police investigation was sent to the Crown Prosecution Service for a charging decision. The Crown Prosecution Service considered this evidence in early October 2019 and stated it supported Adult A's claim of self-defence, that the force used was reasonable and that there was not a reasonable prospect of conviction, so no further action was to be taken.

The DHR process

6. The decision to hold the Domestic Homicide Review was taken on in November 2018 having decided that the criteria set out within The Act was met. The independent chair and author was appointed in December 2018 and a panel of agency representatives was formed.

7. The wish of the female subject of the DHR was for her to be represented in the report(s) as Adult A and for her deceased husband to be represented as Adult B.

Contributors to the Domestic Homicide Review

8. Individual Management Reports (IMRs) were requested from the agencies that had been in contact with or providing services to both Adult A and B. The objective of the IMRs which form the basis for the DHR was to provide as accurate as possible an account of what originally transpired in respect of the incident itself and the details of contact and service provision by agencies with both the subjects of the DHR.

9. The IMRs were to review and evaluate this thoroughly, and if necessary, to identify any improvements for future practice. The IMRs have also assessed the changes that have taken place in service provision during the timescale of the review and considered if changes are required to better meet the needs of individuals at risk of or experiencing domestic abuse.

10. A number of agencies contributed to the review through the submission of Individual Management Reviews and the provision of initial scoping information. Those agencies were:

- Devon County Council Children's Services
- Devon Partnership NHS Trust
- Devon and Cornwall Police
- GP surgery – primary care
- Primary School
- Splitz Support Service
- Together Drug and Alcohol Services
- Virgin Care

Other contributors to the DHR

11. The chair of the panel made contact with Adult A by email and telephone. A face to face interview was conducted with Adult A. Her insights have helped to inform the panel in its thinking.

12. The Chair also contacted the family of Adult B. Following an exchange of letters, the sister of Adult B, identified in the report as Adult C, wished to contribute to the Domestic Homicide Review on behalf of Adult B's family. This discussion took place by telephone on 8 July 2019. Her views have helped to inform the panel in its thinking.

The Domestic Homicide Review Panel Members

Table 1:

Steve Appleton	Managing Director Contact Consulting – Independent Chair
Chrissy Stower	Splitz Devon Domestic Abuse Services
Dr Brian Bennett	GP Service
Kensa Harris	Together Devon Drug and Alcohol Services
Natasha Rowland	North Devon Council
Penny Rogers	Devon Partnership Trust

DCI Stu Caven (now retired)	Devon and Cornwall Police
DS Phil Hale	Devon and Cornwall Police
DCI Nicky Seager	Devon and Cornwall Police
Sara Wright	NEW Devon CCG & South Devon Torbay CCG
Kevin Kenna	Children's Social Care, MASH

13. The members of the panel were independent and had no prior contact with the subjects of the Domestic Homicide Review or knowledge of the case.

The Overview Report author

14. The independent Chair of the panel and author of the DHR Overview Report is Steve Appleton. Steve trained as a social worker and specialised in mental health, working as an Approved Social Worker. During that time, he worked with victims of domestic abuse as part of his social work practice. He has held operational and strategic development posts in local authorities and the NHS. Before working independently, he was a senior manager for an English Strategic Health Authority with particular responsibility for mental health, learning disability, substance misuse and offender health.

15. Steve is entirely independent and has had no previous involvement with the subjects of the DHR. He has considerable experience in health and social care and has worked with a wide range of NHS organisations, local authorities and third sector agencies. He is a managing director of his own limited company, a specialist health and social care consultancy.

16. Steve has led reviews into a number of high profile serious untoward incidents particularly in relation to mental health homicide, safeguarding of vulnerable adults, investigations into professional misconduct by staff and has chaired a Serious Case Review into an infant homicide. He has chaired and written a number of DHRs for local

authority community safety partnerships across the country. He has completed the DHR Chair training modules and retains an up to date knowledge of current legislation

17. Steve has had no previous involvement with the subjects of the review or the case.

Terms of Reference

- Examine the events leading up to the incident, including a chronology of the events in question.
- Review the interventions, care and treatment and or support provided. Consider whether the work undertaken by services in this case was consistent with each organisation's professional standards and domestic abuse policy, procedures and protocols including Safeguarding Adults.
- Review the communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessment and management and the care and service delivery of all the agencies involved.
- Identify any care or service delivery issues, alongside factors that might have contributed to the incident.
- Examine how organisations adhered to their own local policies and procedures and ensure adherence to national good practice.
- Review documentation and recording of key information, including assessments, risk assessments, care plans and management plans.
- Review the impact (or otherwise) of homelessness upon the subjects of the review and the way in which agencies responded to their needs.
- Examine whether services and agencies ensured the welfare of any adults at risk, whether services took account of the wishes and views of members of the family in decision making and how this was done and if thresholds for intervention were appropriately set and correctly applied in this case.
- Examine whether practices by all agencies were sensitive to the gender, age, disability, ethnic, cultural, linguistic and religious identity of both the individuals who are subjects of the review and whether any additional needs on the part of either were explored, shared appropriately and recorded.

Key findings and conclusions

18. Having reviewed and analysed the information contained within the IMRs and having considered the chronology of events and the information provided, the panel has drawn the following conclusions:

19. Overall the standard of primary care was good, but there was more that could have been done to proactively gather information and liaise and communicate with other agencies.

20. The lack of detailed discussion between the GPs and Adult B about his home circumstances and his relationship with Adult A represents a missed opportunity to gather a more holistic picture of the issues that may have been influencing his mental health and alcohol misuse. These connections were not actively explored or drawn out. In addition, there does not appear to have been any use of routine enquiry with him, nor with Adult A when she presented with the children, one of whom had physical symptoms that were attributed to stress resulting from the marital breakdown.

21. The school provided appropriate pastoral support to the children and responded to the information contained in the Vulnerability Screening Tools they received. They actively supported both children.

22. Throughout their contact with Adult A the school were reassured by her about the home situation and accepted these reassurances. Although this may have been reasonable, given they had no reason to challenge this, these assurances were accepted at face value. This is not to directly criticise the school, but it serves to highlight the challenge schools and their staff face in responding to the variety of concerns and issues that their pupils and their parents can be experiencing.

23. The engagement of Splitz, a domestic abuse organisation, was sporadic and tended to be conducted by phone or text message. This was at Adult A's request. She did

engage with the service but this was sometimes difficult as a result of working full time and looking after her two children. There was a change in worker at Splitz during the time Adult A was engaged with the service. The input of Splitz was beneficial to Adult A, who, as a result of their engagement, felt she understood better what domestic abuse was, and had not done so before.

24. The risks associated with Adult B's mental health and alcohol misuse were well known and recognised by Devon Partnership Trust and there were appropriate and regular discussions about his level of risk in relation to self-harm and his risk to others. What is less clear is how these risk assessments were updated in response to changes in his behaviour or mental state. The Devon Partnership Trust services' knowledge and understanding of matters relating to domestic abuse appears to have been limited.

25. There was evidence of good practice in relation to joint working with the drug and alcohol service, through the conducting of a joint visit. The extent to which the services collaborate and communicate is less clear and it would be expected that regular contact would be established and maintained between them in cases such as that of Adult B.

26. Devon Children Social Care Services did not proceed with enquiries relating to safeguarding concerns in relation to the family. These decisions were taken based on information from Adult A and were not routinely overseen or agreed by more senior staff within the Multi-Agency Safeguarding Hub.

27. There were gaps in knowledge and information and there was a lack of triangulation of the information that was held. Although each enquiry was taken on its own merit, the lack of cross referencing to previous enquiries meant that a fuller, historically informed picture was not formed, and a pattern of intelligence was not established.

28. Decision making about proceeding with safeguarding enquiries by Devon Children Social Care Services through the Multi-Agency Safeguarding Hub was inconsistent with local policy and expected practice and failed to address the concerns and risks being expressed.

29. Adult B had experienced significant emotional distress during his childhood, which appears to have included physical abuse. The impact of these Adverse Childhood Experiences on his psychological health and wellbeing does not appear to have played any part in the thinking of those health professionals who encountered him.

30. By her own admission, throughout her interactions with organisations, Adult A appears to have sought to downplay the nature of the difficulties she experienced as result of Adult B's mental health and alcohol use, not least in relation to domestic abuse. This manifested itself in her seeking to contextualise and rationalise Adult B's physical abuse towards her through those two issues. As a consequence, Adult A appears to have felt that Adult B's actions were not unusual and were representative of someone coping with the breakdown of a long-term relationship and who was experiencing depression and alcohol use. At the time Adult A was not aware that the behaviour was coercive control. Adult B was using his own issues to control her and make her feel she had no choices.

31. There were opportunities to intervene earlier and these were not grasped. In particular the incident involving Adult B and the removal of weapons in the context of a mental health crisis should have been a chance not only for an assessment of his mental health, but for a multi-agency, multi-disciplinary discussion about the wide range of issues he faced as well as those experienced by Adult A and their children.

32. The assurances provided by Adult A about her safety were too easily accepted. A lack of professional curiosity and deeper probing meant that the true extent of risk, particularly in the earlier stages of contact, was not realised. There does not seem to have been any clear process for swifter escalation and the Multi-Agency Risk Assessment Conference process did not result in any mitigation of the risks.

33. It is clear that Adult A was a victim of domestic abuse over a sustained period of time and it had a direct impact on her. The abuse was both coercive, controlling and also manifested itself in physical violence towards her.

34. That Adult B lost his life as a consequence of his abusive behaviour has had profound ramifications, both practically and psychologically for all those who knew him.

Recommendations

35. The Domestic Homicide Review Panel made the following recommendations arising from the review:

36. R1 - Early intervention is available for couples whose relationships are showing signs of disharmony and conflict (unhealthy relationships).

37. R2 - Use of clinical enquiry for domestic abuse is embedded in all GP surgeries in Devon. This should include enquiry into relationship health and abusive behaviour.

38. R3 - Adequate provision is made clearer/available to perpetrators of domestic abuse to support them to change their abusive behaviour.

39. R4 - The identification of the registered GP for the Multi-Agency Risk Assessment Conference notification letter must have a revised process put in place that ensures there is no longer a reliance on individuals to offer this information.

40. R5 - Individual agencies offer interventions to meet their own agency criteria. Further exploration is needed to look at how multiple needs of an individual and their family (mental health, substance misuse and domestic abuse) can be addressed together.

41. R6 - Change the use of victim blaming language, particularly within statutory services as this marginalises the victim/survivors and makes it harder for them to engage with help and reinforces the abuser's power and allows them to avoid taking accountability for their actions.

42. R7 - Raise awareness in schools about domestic abuse, referral pathways and appropriate responses by the school.