Permission has been granted by the Home Office to publish this final report

Safer West Sussex Partnership

Domestic Homicide Review Overview Report

FINAL REPORT INTO THE DEATH OF ADULT A in 2011, in Sussex

Report produced by Councillor David Simmons

Date: 1 February 2013

CONTENTS

Permission has been granted by the Home Office to publish this final report

Please note that the subjects of this report have been anonymised throughout.

1. INTRODUCTION AND BACKGROUND

1.1. Introduction

This Domestic Homicide review examines the circumstance surrounding the sudden unexpected death of an Adult A in West Sussex in 2011.

Sussex Police were called at 14.14 hours, on a date in 2011, to an incident by Adult B stating that he had killed his wife and attempted to kill himself by stabbing himself in the leg. An ambulance was requested to attend with Sussex Police.

Adult B was arrested and treated for his injuries and taken to a hospital where he was assessed by a psychiatrist, on release from hospital he was taken to a police custody centre and charged with the murder of Adult A.

Adult B appeared at Crown Court 7 26 January 2012 where he pleaded guilty to the manslaughter of his wife, Adult A, on the grounds of mental illness. He was made subject to a S.37 Hospital Order and a S.41 Detention Order.
Since this time he has remained detained at her Majesty's pleasure.
Therefore there has not been a trial.

1.2. Reason for conducting the Review

Domestic Homicide Reviews (DHRs) came into force on 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The act states that a DHR should be 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) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death'

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
- Identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

The guiding principles which underpin this review are:

- **Impartiality** – those conducting the review should not have been directly involved with the victim or the family
- **Thoroughness** – all important factors should be considered
- **Openness** – there should be transparency with no suspicion of concealment
- **Confidentiality** – due regard should be paid to the balance of individual rights and the public interest
- **Co-operation** – the agreed procedure and statutory guidance contained within Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2011 should be followed.
- **Resolution** – action should be taken to implement any recommendations that arise as soon as possible

1.3. Process of the review

A DHR was recommended and commissioned by the West Sussex Strategic Community Safety Partnership in line with the expectations of Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2011. The guidance is issued as statutory guidance under section 9(3) of the Domestic Violence Crime and Victims Act (2004)

The Chair of the West Sussex Strategic Community Safety Partnership (WSSCSP) established Adult A's homicide met the criteria of a subject of a DHR by applying the definition set out in paragraph 3.8 of the guidance.

Agencies and interested parties were notified of the requirement to secure any records pertaining to the homicide to inform the subsequent overview report.

The Chair was agreed to be Councillor David Simmons.

The process began with an initial meeting 7 July 2011, to consider the information which had been sought from a total of 43 organisations across Sussex and Surrey, that could have potentially had contact with Adult A and/or Adult B prior to the homicide.
The full list of organisations appears at Appendix A.

Only two organisations had any knowledge of Adult A and one of Adult B but this knowledge was unrelated to the context of this review, there were therefore no Independent Management Reviews commissioned

The review panel met a further two times on the following dates:
21 September 2011 and 24 November 2012.

The DHR Panel comprised:

REP FOR:	**NAME**	**POST**
	Councillor David Simmons	Independent Chair
West Sussex County Council	Sue Cart	Head of Safeguarding
West Sussex County Council	Trish Harrison	Principal Manager for Domestic and Sexual Violence
Sussex Police	Alison Eaton Carwyn Hughes	Detective Chief Inspectors
Sussex Community NHS Trust	Sue Giddings	Deputy Director Operations & Clinical Services
NHS West Sussex	Stephanie Stockton	Head of Safeguarding
Horsham District Council	Natalie Brahma-Pearl	Director of Community Services
Surrey & Sussex Probation Trust	Jane Browne	Director Offender Management

The Chair and author of the Domestic Homicide Review is Councillor David Simmons Chair of the West Sussex Strategic Community Safety Partnership. Councillor David Simmons has had no previous involvement with the subjects of the review or the case.

1.4. Time Period

The review began on 7 July 2011 and concluded on 1 February 2013.

The primary focus of the review will be from 9 June 2009 until the date of the death.

Terms of Reference

The purpose of the Domestic Homicide Review is to:

- Ensure the review is conducted according to best practice, with effective analysis and conclusions of the information related to the case.

- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence including their dependent children.

- 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.

In addition the following areas will be addressed in the Individual Management Reviews and the Overview Report:

- Adult A had no known contact with any specialist domestic abuse agencies or services. The review will address the circumstances of this tragic incident, in which Adult A died. Whether there were any warning signs and whether more could be done in West Sussex to raise awareness of services available to victims of domestic violence.

- Whether family, friends or colleagues want to participate in the review and if so whether they were aware of any abusive behaviour from Adult B to Adult A, prior to the homicide.

- Whether there were any barriers experienced by Adult A or her family/ friends/colleagues in reporting any abuse in West Sussex or elsewhere, including whether she knew how to report domestic abuse should she have wanted to.

- Whether Adult A had experienced abuse in Surrey, prior to coming to Sussex and whether this experience impacted on her likelihood of seeking support in the months before she died.

- Whether there were opportunities for professionals to 'routinely enquire' as to any domestic abuse experienced by the victim that were missed.

- Whether Adult B had any previous history of abusive behaviour to a family member or intimate partner and whether this was known to any agencies.

- Whether there were opportunities for agency intervention in relation to domestic abuse regarding Adult A, or Adult B.

- The Review should identify any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and / or services in the county.

- The Review will also give appropriate consideration to any equality and diversity issues that appear pertinent to the victim, perpetrator e.g.

Age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

- Due regard will be given to the criminal proceedings and any H.M. Coroner's Inquest.

The review will consider any other information that is found to be relevant.

1.5. Individual Management Reviews

There were no organisations commissioned to undertake Independent Management Reviews as none could be found that had any knowledge of or contact with Adult A or Adult B prior to this homicide.

Instead this report is based on information provided by the two organisations that had knowledge of Adult A and Adult B, although this knowledge was not in the context of domestic violence.

These organisations are:
Sussex Police
Horsham District Council

The report's conclusions represent the collective view of the DHR panel, which has the responsibility, through its representative agencies, for fully implementing the recommendations from the review. There has been a full and frank discussion of all the significant issues arising from the review

Confidentiality

The findings of each review are confidential. Following acceptance of this report by the West Sussex Strategic Community safety Partnership a confidential "briefing note" encapsulating key messages and agreed recommendations will be circulated to relevant managers in each of the organisations that contributed to this DHR

Dissemination

Whilst key issues have been shared with contributory organisations the report will not be fully disseminated until clearance has been received from the Home Office Quality Assurance Group. In order to secure agreement pre – publication drafts of the report were seen by the membership of the review panel (as listed at 1.3). The clearance to publish the report was received from the Home Office by a letter dated 23 August 2014.

The content of the Report is anonymised in order to protect the identity of the victim, the perpetrator, relevant family members, staff and others, and to comply with the Data Protection Act 1998. The overview report will be produced in a form suitable for publication with any redaction before publication.

1.6. Involvement of family/friends/colleagues

In domestic homicides, members of informal networks, such as friends, family members and colleagues may have detailed knowledge about the Victim's experiences. The Review Panel considered carefully the potential benefits gained including individuals from both the victims and perpetrators networks in the review process and extended invitations to family and friends.
Adult C, the brother of Adult A met with the Chair of the Review Panel and Trish Harrison, a member of the Review Panel, 23 January 2013 and a further meeting took place 7 April 2014 where further comments, made by Adult C, were considered prior to the publication of this report.

2. DOMESTIC HOMICIDE REVIEW PANEL REPORT

2.1. Summary of the case

Adult A and Adult B had been married for forty two years and previously lived in Surrey. The couple had no children and the only known relative being Adult C, the brother of Adult A.

The first time that this couple came to the attention of any agency in the context of domestic violence was on the date of death in 2011 when Adult B phoned Sussex Police at 14.41 stating that he had killed his wife, Adult A, in the night and he had had attempted to kill himself by stabbing himself in the leg. An ambulance was requested to attend the address with Sussex Police.

Adult B was arrested and treated for his injuries. A murder investigation was commenced by Sussex Police and Adult B was taken to hospital. The body of Adult A was discovered in one of the bedrooms of the house.

Adult B had no police history and no evidence of a history of mental illness could be found. Adult B was assessed at hospital by a psychiatrist after which he was charged for the murder of Adult A and taken into custody by Sussex Police.

On 26 January 2012, Adult B pleaded guilty to the manslaughter of Adult A on the grounds of mental illness. He was made subject to a S.37 Hospital Order and a S.41 Detention Order, meaning that he cannot be granted leave, transferred to another hospital or discharged without the consent of the Secretary of State for Justice.

2.2. Analysis of friends/family/colleagues information

Adult C described that Adult B did tend to suffer from mood swings and had done so for a long period of time, he said that his sister accepted this and had found ways of coping with Adult B's mood swings.

Adult C stated that he had no concerns for his sister and that Adult A and Adult B, were a happy, devoted and successful couple. Adult C's view was that the couple loved each other and were very happy. He did not have any knowledge of any violence prior to the tragic death of his sister and did not feel that there had been any issues over which his sister would need, or want, to contact agencies or organisations.

- Sussex Police also described that a number of neighbours had provided statements but not one of these had expressed any concerns regarding Adult A and Adult B's relationship, but had described a nice couple who appeared to love each other.

2.3. Analysis of Individual Management Reviews

There were no Individual Management reviews commissioned as none of the forty three agencies contacted had any relevant information or contact.

In the case of the two agencies which had some unrelated knowledge this was as follows:

Horsham District Council had record of Adult A in connection with a planning application.

Worthing Hospital had contact with Adult B for a minor gardening injury.

There was also confirmation that Adult A had been registered with a GP in Surrey until 2007. Subsequent to that there was no trace of registration of either Adult A or Adult B. The GP records relating to 2007 are outside the scope of this review. The panel considered that Adult A and Adult B may have had private healthcare but was not able to ascertain this which is reflected in recommendation 5.1.

3. CONCLUSIONS AND LESSONS LEARNED

3.1. Agencies working together

West Sussex has a long history of successful partnership working in the field of domestic violence. The request for information to be provided to and shared with the Domestic Homicide Review Panel was responded to in a timely and considered manner by all agencies across West Sussex and the agencies in Surrey also responded within the required timescales.

3.2. Good Practice

West Sussex is one of the best resourced counties in the UK in terms of the following domestic violence services:

- WORTH Services, which is nationally recognised as good practice, has been established since 2004 and provides an Independent Domestic Violence Advisor Service (IDVA) 7 days a week across the county. The IDVA Service is available to male and female victims and has assisted over 10,000 victims of domestic violence. IDVAs are based in the Emergency Departments of all major hospitals in the county and also with Sussex Police. The service has 17 IDVAs, 3 of which are male and a further 4 support staff.

- There are four Multi Agency Risk Assessment Conferences (MARACs) in West Sussex, each meeting monthly and during 2011/2012 over 750 cases were referred to the MARACs.

- There are frequent advertising campaigns to raise the awareness of domestic violence within the community and information is distributed to every household in the county

- The West Sussex County Council Domestic and Sexual Violence unit have worked with Crime-stoppers to launch a campaign to encourage third party reporting of domestic violence.

- The Domestic and Sexual Violence Unit of West Sussex County Council provide regular full day training to a broad range of professionals and other interested parties, including members of the public. Since 2004, over 10,000 people have received domestic abuse training. This training comprises the following one day courses:

    - Understanding Domestic Abuse
      To provide a thorough understanding of the prevalence, nature and effects of domestic abuse and learn how to identify and assist those affected.

    - Reducing the Risk of Domestic Abuse through Multi -Agency Response
      To increase knowledge about the multi-agency support system for high risk families affected by domestic abuse and to increase referrals to MARAC.

    - Living with Domestic Abuse: The Impact on Children
      To raise awareness of the prevalence, nature and effects on children of living with domestic abuse

3.3. Lessons Learned

It is extremely difficult to conduct a Domestic Homicide Review where there has been no relevant contact with any agency or organisation, only one relative, and where there are no traceable records for either subject of any review.

In this case, it is likely that health provision was sourced privately and the Review Panel were surprised to find that due to this it is not possible to ascertain which if any health professionals had been consulted by Adult A, or Adult B.

It is not for the Review Panel to draw conclusions without evidence or to speculate on whether there had been any domestic abuse within this relationship. There is no trace of any person with the knowledge and experience to identify domestic abuse having come into contact with Adult A or Adult B.

3.4. Conclusions

The Terms of Reference have been considered and the following conclusions made.

- No trial has taken place, Adult B remains subject to a S.37 Hospital Order and a S.41 Detention Order. Since this time he has remained detained at her Majesty's pleasure.

- The review has now been conducted with as effective analysis as possible and conclusions related to the case.

- It has been difficult to establish specific lessons to be learned due to the limited and unconnected contact that agencies had with Adult A or Adult B.

- This Review does not conclude that the incident in which Adult A died was other than an exceptional event, due to lack of supporting information and evidence, as there is not enough information available to conclude this. Neither does the Review conclude that that there was any previous history of domestic abuse for the same reasons.

- From all the information available to the Review Panel it does not appear that any agency was lacking in appropriate response in either policy, procedures or actions

- There is always more that can be done within West Sussex to raise the awareness of domestic violence, however the current service provision and awareness raising is significant as described in 3.2

- The information provided by Sussex Police in relation to the views expressed by Adult C and neighbours would appear to indicate that no agency could have predicted or prevented this tragic death.

- As there is a lack of historic evidence of domestic violence the only barriers to Adult A or her friends/family/colleagues reporting the violence appears to be either a lack of knowledge, necessity or desire to do so.

- The panel concluded that there were no missed opportunities to routinely enquire or identify domestic violence, and there had been no opportunities to offer intervention.

- There are no child protection concerns related to this case.

- The review considered the amount of specialist domestic violence training that is available in West Sussex. The number of people attending these courses each year is rising and now approaching 1,500 a year and the panel concluded that domestic abuse training in West Sussex is of high quality, well attended and available to all.

- The panel felt this review has raised significant concerns about the inability to access information held within the private health care sector.

- The panel concludes that all agencies acted appropriately within the context of their contacts with Adult A and Adult B and there was nothing further those agencies could have been expected to have done or to provide to prevent the death of Adult A.

4. RECOMMENDATIONS – Local

4.1. The panel recommends that domestic abuse awareness campaigns be reviewed during 2013/2014, to identify opportunities to describe domestic abuse in vocabulary that could assist more people to recognise signs of domestic abuse.

5. RECOMMENDATIONS – National

5.1. The process and practicalities of accessing private health care records be reviewed and clarified.

Councillor David
Simmons Independent
Chair 1February 2013

Appendix A

Affinity Sutton
Ashford & St Peters
Hospital Crimestoppers
East Surrey Domestic Violence
Forum East Surrey Hospital
Elmbridge Borough Council
Epsom & Ewell Borough
Council Freemasons
Guildford Borough
Council Library Service
Mole Valley District Council
Reigate & Banstead Borough
Council Epsom & St Helier Hospital
Trust Frimley Park Hospital
Horsham District Council
Kingston Hospital NHS
Trust
Nation Domestic Violence
Helpline NHS Surrey
NHS West Sussex
Parish Council
Reigate & Banstead Women's
Aid RISE
Royal Surrey Hospital NHS Foundation
Trust Runnymede Borough Council
South East Coast Ambulance Service
South West Surrey Domestic Violence
Outreach South West Surrey refuge
Spelthorne Borough
Council Surrey GP
Surrey Heath Borough Council
Surrey & Sussex Probation
Trust Sussex Community NHS
Trust
Surrey & Borders Partnership NHS Foundation
Trust Sussex Partnership Foundation Trust (Mental
Health) Sussex Police
Tandridge District Council
Walton, Weybridge & Hersham Citizens Advice
Bureau Waverley Borough Council
West Sussex County Council – Adult Services and Children's
Services West Sussex County Council – Worth IDVA Service
Western Sussex Hospitals Trust-Worthing and St Richards
Hospital Woking Borough Council
Your Sanctuary (was Women's Aid)