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REPORT INTO THE DEATH OF MRS A/2013

Executive Summary

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1. INTRODUCTION

1.1 This executive summary outlines the Domestic Homicide Review process undertaken by the Safe Northumberland Partnership in reviewing the death of Mrs A.

1.2 On Monday 29th April 2013 Mr A contacted police stating he had murdered his wife, Mrs A. Mr A was arrested and taken to Bedlington Police station where he was interviewed, admitted the offence and was charged with murder. He subsequently pleaded guilty to the murder of his wife and received a minimum custodial sentence of 13 years.

1.3 On 30th April 2013, the Safer Northumberland Partnership received formal police notification of the death of Mrs A. Following this, on 17th May 2013, the Northumberland Domestic Homicide Review Core Panel met and agreed that the circumstances surrounding the death of Mrs A met the criteria for a Domestic Homicide Review.

1.4 The review was undertaken in line with Section 9 of the Domestic Violence Crime and Victims Act, 2004. The key purpose in undertaking such a review is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned 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.

2 The Review Process

2.1 The purpose of a Domestic Homicide Review as set out in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 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 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.

2.2 An Independent Chair and Overview Report author were appointed, and the review Panel consisted of the following agencies:

- Northumberland, Tyne and Wear NHS Foundation Trust
- Northumbria Healthcare NHS Foundation Trust
- Northumberland Clinical Commissioning Group
- Northumbria Police
- Northumbria Probation Trust
- Children's Services, Northumberland County Council
- Safeguarding Adults, Northumberland County Council.
- Northumbria Victim Support
- North East Ambulance Service NHS Foundation Trust
- Northumberland Fire and Rescue Service
- Housing Services, Northumberland County Council

2.3 Individual Management Review (IMR) reports were completed by all agencies represented on the Panel, including in cases where little or no contact had taken place.

2.4 In addition to the IMRs information was also provided by Mrs A daughter, who agreed to take part in the review process.

3 Terms of Reference

3.1 The specific terms of reference agreed for this review were:

- If there was a low level of contact with your agency why was this so? Were there any barriers to either the victim or the alleged perpetrator accessing your services and seeking support?
- Was there indication of the victim being isolated by the perpetrator and could this have prevented them from contacting services?
- Were there any other issue relating to this case such as drug or alcohol abuse and if so what support was provided;
- Whether the perpetrator had a history of any violent behaviour and if any referrals were made to services in light of this;
- Whether any risk assessments had been undertaken previously on the perpetrator and whether these had judged risk appropriately;
- Whether the victim was experiencing coercive control on the part of the alleged perpetrator;
- Was there any indication of domestic violence or coercive control occurring before the incident and if so did the victim consider this to be control or domestic abuse;

- Do you hold any information offered by informal networks? The victim or perpetrator may have made a disclosure to a friend, family member or community member.

- Given the commitment of all agencies to "Think Family" to what extent did your contact and involvement with the victim and/or perpetrator result in a formal or informal assessment of the wider family including any children or young people?

3.2 The time period covered by the review was from 29th April 2012 to 29th April 2013 in order to allow for an analysis of issues immediately relevant to the homicide. In addition to this agencies were requested to refer to any issues or contact with Mrs or Mr A outside of this time period that was considered relevant and would inform the analysis of dangerousness and risk.

4 Summary of Agency Involvement

4.1 Mr and Mrs A both had contact with agencies over a period in excess of twenty years, presenting with a number of physical health needs and difficulties relating to alcohol use. In undertaking this review a significant amount of relevant historical information emerged, dating back to 1985, that assisted in building a picture of Mrs A, her lifestyle, her relationship and the abuse which she experienced; as well as background information relating to Mr A. Such information also provided context for the way in which practice around domestic violence has changed within the last twenty years.

4.2 Northumberland Tyne and Wear NHS Foundation Trust had significant contact with Mr A prior to 2000 due to his presenting mental health issues, and from 2000 onwards Northumberland Healthcare NHS Foundation Trust had significant contact with both Mrs and Mr A due to their physical health needs and access to acute medical services.

Northumbria Probation Trust last had contact with Mr A in 2000, although were unable to provide full historic information due to the destruction of records. Northumbria Police had contact, primarily in relation to Mr A, across the time span of the review, while Northumberland CCG had relevant contact through Mr and Mrs A's GPs in the year leading up to the death of Mrs A. Northumberland County Council Children's Services also had some limited contact, both historic and recent.

4.3 Northumberland County Council Strategic Safeguarding Adults Team, Northumberland Fire and Rescue Service and Northumbria Victim Support identified no relevant contact with Mr or Mrs A in relation to this review. The North East Ambulance Service attended the home on the day of the homicide but otherwise identified no pertinent information.

4.4 Mrs A was the victim of assaults by her husband on a number of occasions between 1992 and 2000. Furthermore on a number of occasions from 2006 to 2011 she presented at hospital with indicators of ongoing violence, although these were not fully explored or addressed.

4.5 Mr A was also known to criminal justice agencies in relation to a number of other offences and his offending history dated from 1972 and includes offence of violence, public order, drink driving and acquisitive offences. He also had a history of depression and suicide attempts. The primary focus in his historical contact with agencies appeared to be upon his alcohol use, and the violence he exhibited was viewed as peripheral to this. In more recent years his history of violence was also 'lost' from current records, due to either information not having been shared, or linked to the agencies record retention policies. This resulted in no consideration being given to this in his more recent contact with agencies.

5 Lessons Learned and Conclusions

5.1 As much of the information relating to agencies contact with Mrs or Mr A in relation to known domestic violence was significantly historic, the review process highlighted that some of the omissions that occurred have since been addressed through the introduction of systems and processes which should significantly assist in preventing such instances happening in the future. These include enhanced systems for communicating and information sharing between agencies; increased training provision in relation to domestic abuse and violence; and greater recognition of domestic abuse within policies and procedures, including the introduction of specific domestic abuse risk assessments. ~~been addressed by changes in both national and local policy and practice.~~ One of the key areas within the above was also the recognition of domestic violence as a child protection issue, something that was significantly missing in historic practice.

5.2 As well as the issues in relation to such historic practice, the review also identified evidence in more recent practice (from 2006 onwards) of a 'narrow' approach by agencies in dealing with presenting problems. This can be seen in a lack of further assessment or exploration of the broader context that led to a failure to identify possible ongoing domestic abuse and thus address it. In considering why this may have occurred a number of key lessons learned were identified.

5.3 **Lack of access within agencies to historical information.**

5.3.1 Despite Mr A's history of violence against Mrs A, including two severe assaults in 1992 and 1994, there is no evidence that agencies working with them subsequent to the year 2000 were aware of this. This can been seen to have impacted in relation to instances in which potential indicators for further enquiry were not identified; had such historical information been known this may have acted as an additional prompt.

5.3.2 This highlighted the need for information around domestic violence to be both shared appropriately and also recorded in such a way that it can be easily identified and accessed by staff at a later stage. Within this case, the first issue around the sharing of the information can primarily be seen to have arisen due to the time period in which events occurred. It has been identified that there now exists more robust systems for the identification of risk and the multi-agency sharing of information through Safeguarding and MARAC processes in cases where a significant risk is identified.

5.3.3 However, the second issue around recording of the information was highlighted within the IMRs of the CCG, NHCFT and Northumbria Probation Trust. In the case of the CCG and NHCFT their review of files revealed that the information was previously recorded but not easily accessible due to it not having been coded or flagged on records. In the case of Probation the information had been destroyed in accordance with their national retention of records policy. While it is unrealistic that as a result of this review all historic information will now be brought forward onto existing records; the learning that can be identified is to ensure that current systems allow concerns or risks to be coded or flagged in such a way that they are accessible to staff and do not become lost in the future.

5.3.4 While the difficulties around access to historical information have been identified in relation to the three agencies above, solely due to their level of involvement with this case, the panel identified that this is an issue that could potentially occur across any number of services. The evidence presented around the impact on practice would therefore support the need for this to be considered by all agencies.

5.4 **Failure to recognise potential indicators of abuse and to undertake targeted enquiry in relation to domestic violence.**

5.4.1 Some of the key events in the more recent history of Mrs A highlighted

missed opportunities to undertake selective/targeted enquiry on the basis of presenting risk indicators. As a result of this no specific risk assessments were undertaken, no multi agency risk management occurred, and no referrals were made to specialist support services. Furthermore what can be seen to be missing throughout this review is the perspective of Mrs A in relation to the domestic violence she experienced and her ongoing home situation.

5.4.2 These missed opportunities occurred within Mrs A's contact with A&E and at appointments with her GP. As has already been identified, knowledge of previous history of domestic violence may have further prompted staff to consider this and undertake further questioning. However even without this there were sufficient risk indicators present on these occasions to suggest that further enquiry should have taken place. Such enquiry was also supported by both national and local policy and practice guidelines for health staff. These omissions therefore indicate an awareness and training need among staff within NHCFT and the CCG around recognising domestic violence indicators and being confident in 'asking the question' about abuse.

5.4.3 Finally, in relation to supporting staff within the A&E setting the Panel identified that in light of the missed opportunities within the emergency setting, the on-site presence of an Independent Domestic Violence Advocate (IDVA) would have supported staff in increasing their awareness of domestic abuse and violence as well as providing direct referral routes for victims into the MARAC process. In the Case of Mrs A her attendance at A&E with the presenting concerns would have been the ideal opportunity for her to be engaged with and a full risk assessment completed.

5.4.4 The practice of having IDVAs present within hospital settings is currently recommended by CAADA (Co-ordinated Action Against Domestic Abuse). CAADA identify that 'co-locating…IDVAs in A&E and

maternity units will create a platform of sustainable national provision'.[1] Furthermore a regionally based pilot in North Tyneside between September 2012 and March 2013 was found to have positive results both in raising awareness of hospital staff in relation to domestic abuse as well as having someone on site to whom they could seek advice and guidance from. However due to funding issues, it was identified that this service would not continue. Panel discussions identified that ongoing regional issues around the lack of mainstream funding of IDVA services meant that a commitment to funding for such a service within the hospital setting could not be given.

5.4.5 In relation to the above, as part of their Violence against Women and Girls' Strategy, the government part funded 144 IDVA posts nationally until 2015. However with such funding due to come to an end there is a considerable risk to the provision of such services within the Northumberland area. This is despite domestic abuse being seen a priority within the North East's regional Violence against Women and Girls' strategy, as well as priority within the Northumberland Community Safety Strategy. Within CAADA's 'Insights 1: A place of greater safety' (2012), it is recommended that mainstream funding for such IDVA services be achieved through the formalising of shared responsibility for this through a pooled budget between the Local Authority (including Public Health), Clinical Commissioning Groups and Police and Crime Commissioners. It was felt by the Panel that in order to achieve this there was a need for national steps to be taken to support this.

5.5 Difficulties in addressing complex needs.

5.5.1 A further theme that emerged throughout this review was the presence of the complex trio of domestic violence, substance misuse and mental health concerns in the case of both Mrs and Mr A. This can be seen to

[1] 'CAADA (Coordinated Action Against Domestic Abuse) Insights 1: A place of greater safety', November 2012.

have impacted in a variety of ways in relation to their contact with agencies. In earlier contact by Mr A with mental health services it was identified that there was a focus upon his mental health and particularly his alcohol use, as opposed to his use of violence and the risk related to this. In more recent contact this can perhaps also be seen to play a role in Mrs A's contact with NHCFT, where there were repeated references to her alcohol use yet little recognition of indicators of domestic violence. Mrs A also presented in January 2012 at an outpatient appointment in which reference was made to her 'anxiety' impacting upon her physical health, yet there was no evidence of further exploration or follow up regarding this.

5.5.2 Mr and Mrs A alcohol use has emerged as a significant factor in agencies contact with them, often being referenced within their records. However over time attempts to engage them in assessment or intervention around this appears to have declined. Throughout their contact with NHCFT signposting and referral to substance misuse services did occur, but these were frequently refused and became increasingly intermittent. The analysis of such contact revealed a number of missed opportunities for further signposting or referral in relation to this.

5.5.3 There were also missed opportunities for further referral or assessment identified within the analysis regarding Mr A's mental health presentation. These included his attendance at hospital appointments in relation to his chronic pain, where little consideration appears to have been given to the impact of this on his mental health despite references being made to his history of depression and alcohol use. Furthermore during his contact with his GP in the year leading up to the homicide Mr A was signposted to alcohol services yet no referrals were made to mental health services despite indicators of significant anxiety that was impacting on his ability to leave the house.

5.5.4 Due to the complex interplay of substance misuse, mental health

problems and domestic violence, as seen above, this can lead to domestic violence being 'masked' by chaotic presentation or a focus on other issues. Similarly a failure to engage with services offered can lead to decreasing attempts by professionals to address these, which results in reduced opportunities for intervention, assessment and support. In the case of a victim of abuse this also reduces opportunities for disclosure; whilst, in case of a perpetrator, this can result in a failure to address factors that may impact on the level of risk they pose.

5.6 Agencies retention and disposal of records

5.6.1 Due to the historical nature of much of the domestic violence within the case of Mrs A, a factor that became apparent at an early stage in this review was the differing access of agencies to historical information. The impact of this in terms of recent practice has already been discussed in terms of agencies lack of access to historical information to inform risk. However it was also felt by the Panel that this raised a broader issue in relation to the disparity between different agencies record retention and disposal policies that prompted further consideration in relation to the impact on review processes such as DHRs and Serious Case Reviews.

5.6.2 It was identified that agencies often have specific time periods for the disposal of records following last contact, although these can be subject to review when there is deemed to be significant information relating to risk. However, the methods for determining if risk information is 'significant' also varies between agencies and is sometimes a subjective process dependent upon the review of records by individual staff members.

5.6.3 It was felt that the above disparities make it difficult to undertake comprehensive reviews of practice, as well as resulting in the potential for critical information to be 'lost' in relation to risk. All agencies agreed

that action was necessary to address this but that this could not be taken on a local level. As a result a formal recommendation arose for this to be considered by all agencies on a national level.

6 RECOMMENDATIONS

6.1 Three formal national recommendations were identified as result of this review. The first relates to the National Probation Service, the second to the commissioning of IDVA services, while the third arose as a result of broader concerns arising around the retention and disposal of records.

The National Probation Service (NPS) to review their current process for recommending curfews, and identify and implement any steps that can be taken to improve identification of any concerns relating to domestic violence in cases where it is not evident from the nature of the index offence or conviction history.

The Home Office to consider making the provision of IDVA services a statutory requirement in order to support regional commitment to the funding of IDVA services.

The Information Commissioner's Office to consider agencies' current policies for the retention and disposal of records in light of the impact of this upon the ongoing identification and management of risk in domestic abuse cases. Policies should also take into account the importance of retention issues for processes such as DHRs and other safeguarding and serious case reviews.

6.2 As has also been identified throughout the conclusions of this report a number of local recommendations have been made to support and develop ongoing actions that have already been undertaken by agencies involved in the review. These are summarised below along with three further local recommendations around the dissemination of lessons learned, training and the feedback of single agency recommendations.

Local Recommendation 1:
All partnership agencies to provide the Safer Northumberland Partnership with details about how historic or current information relating to domestic abuse is recorded and cross referenced on case files; whether this is felt to be sufficient to alert staff to concerns in relation to victims, perpetrators and children; and whether there are any actions needed to address gaps or difficulties identified.

Target date: October 2014

Local Recommendation 2:
Northumberland CCG and NHS England to include, within their planned audit on the use of 'read codes', a question to capture the number of GPs who have undertaken training in relation to domestic violence. The Safer Northumberland Partnership to seek feedback from Northumberland CCG and NHS England in relation to this audit and any actions to be taken as a result of this.

Target date: October 2014

Local Recommendation 3:
NHCFT to undertake a review of optional domestic violence and abuse training in order to identify which frontline staff in emergency settings are accessing such training. The results of the review to be used to identify whether further targeting of front line staff in acute services is needed and whether to achieve this such training should be made mandatory. NHCFT to

provide feedback to the Safer Northumberland Partnership in relation to this review and any actions to be taken as a result of this.

Target date: October 2014

Local Recommendation 4:
NHCFT, Northumberland CCG and NHS England to make all frontline staff aware of the AVA Complicated Matters toolkit and online training and how they may access this. NHCFT, Northumberland CCG and NHS England to share how this is achieved with the Safer Northumberland Partnership.

Target date: October 2014

Local Recommendation 5:
The Safer Northumberland Partnership to deliver multi agency briefings, for staff within both voluntary and statutory agencies, that bring together key learning points from all Domestic Homicide Reviews conducted locally.

Target date: October 2014

Local Recommendation 6:
All partnership agencies to provide the Safer Northumberland Partnership with details of how key learning from this review has been disseminated to frontline staff.

Target date: October 2014

Local Recommendation 7:
All partnership agencies to identify, and feedback to the Safe Northumberland Partnership, whether key learning points from this review are already addressed in relevant training programmes, and actions to be taken to

incorporate it where gaps are identified. The key learning points have been identified as:

- The importance of accessing and considering historical information within assessments.
- The need to recognise potential indicators of abuse and to undertake targeted enquiry in relation to domestic violence.
- The interplay of substance use, mental health issues and domestic violence and the need to ensure that focus on one area does not lead to failure to identify and address concerns in relation to others.

Target date: October 2014

Local Recommendation 8:
NHCFT to share progress on their single agency recommendations with the Safer Northumberland Partnership

Target date: October 2014

6.3 In addition to the local recommendations from this review, **Northumbria Healthcare NHS Foundation Trust** included within their IMR a number of single agency recommendations to address specific issues identified. They also provided a comprehensive action plan with timescales for implementation. These are fully endorsed by the findings from this DHR.

- A 'Tick Box' to be introduced to A&E admission documentation to ask that Domestic Abuse/Safeguarding concerns have been considered and actioned. *Target date: end of January 2014.*
- Specific Safeguarding Adults supervision to include Domestic Abuse process to be made available to A&E teams, Minor Injury Units, Critical Care, Outpatient Clinics and Safeguarding Link Staff.
- Addition of a reference page for Substance Misuse into the 'One Stop' Safeguarding file. *Completed.*

- Introduce a pocket sized colour coded 'Governance MATRIX'. The MATRIX will give the staff a quick reference to what needs to be considered when information sharing with the Police and other agencies when such agencies need to be called to support patients in the care of NHCFT. *Target date: end of March 2014.*
- Review how medical files are achieved safely re insertion of outpatient files/letters. *Target date: end of January 2014.*