Wiltshire Domestic Homicide Review

EXECUTIVE SUMMARY OF THE OVERVIEW REPORT

Into the homicide of Adult M 8th April 2013

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Section One: Introduction

This Domestic Homicide Review examines the circumstances surrounding the death of adult M in Wiltshire.

1.1 At 2214hrs Monday 8th April 2013 the first of two 999 calls were made from adult M's home address. The caller was her husband adult R, who said, "I've stabbed my wife".

1.2 Following police attendance at the address, adult M was found following initial treatment at the scene, she was then airlifted to hospital. At 0120 hours on Tuesday 9th April 2013, she was pronounced dead.

1.3 Adult M's husband, Adult R, was arrested for attempted murder at the scene at 2225 hrs on 8th April 2013. He told the arresting officers what he had done, but gave no reason as to why, other than he had lost it because she was always on at him. On arriving at the Police Station after his arrest, his blood alcohol level was found to be three times over the drink drive limit.

1.4 On 9th April 2013 adult R was charged with Adult M's murder. He was found guilty of murder on 27th January 2014 and sentenced to life imprisonment with a tariff that he serves a minimum of 16 years in jail.

Section Two: The Review Process

2.1 This summary outlines the process undertaken by the Wiltshire Domestic Homicide Review Panel in reviewing the murder of Adult M.

2.2. A Domestic Homicide Review (DHR) was recommended and commissioned by the Wiltshire Community Safety Partnership in line with section 9 of the Domestic Violence, Crime and Victims Act 2004 and the expectations of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2011. The Home Office was informed of the intention to conduct a DHR on the 9th May 2013.

2.3. The process began with an initial Review Panel meeting on 2nd July 2013 of agencies that potentially had contact with Adult R, Adult M and her children prior to the point of Adult M's death.

2.4. Adult M's family was contacted at the start of the Review and were kept informed throughout the Review by the Chair. Adult M's mother and two daughters (now adults) provided information for the Panel and her two sons said they had nothing to add but wanted their elder sister to be their link with the Review. Adult M's mother and daughters who were in contact with the Homicide Support Service were provided with details of the charity AAFDA by the DHR Chair. Adult R's family were not contacted as he had no contact

with them for many years and they had informed the police that they did not wish to be contacted by the Review.

2.5 On 13th and 18th March 2014 the completed Overview Report was discussed with the victim's mother and daughters. They expressed their thanks for the thoroughness of the Review and their agreement with the conclusions and action plans. The victim's elder daughter asked that it be stressed that they accept that no one could have changed what happened to their mother; "as well as the family, a lot of people particularly her alcohol counsellor, the police and probation tried really hard to get her to leave him". The family blame only Adult R for Adult M's death.

2.6 The agencies participating in this case review are:-

Avon & Wiltshire Mental Health Partnership NHS Trust (AWP)*
Barnet Council Social Care*
Kennet House Refuge*
NHS Wiltshire CCG*
Norfolk Constabulary*
Sanctuary Housing Group*
Splitz Support Service*
Wiltshire Council Housing Allocations and Option*
Wiltshire Council Children and Families
Wiltshire Council Environmental Health*
Wiltshire Council Revenue and Benefits*
Wiltshire Council Safeguarding Adults
Wiltshire Crown Prosecution Service*
Wiltshire Magistrates Courts Service*
Wiltshire MARAC*
Wiltshire MAPPA*
Wiltshire Police*
Wiltshire Probation Trust*
IDVA Service Victim Support*

2.7 Agencies were asked to give chronological accounts of their contact with the perpetrator, victim and her children prior to the homicide. Where there was no involvement or insignificant involvement, agencies advised accordingly. In line with the Terms of Reference (appendix one), the DHR has covered in detail the period from 1st January 2008 to 8th April 2013, although agencies have included relevant contacts prior to 2008.

2.8 Nineteen agencies / multi-agency partnerships were contacted about this review. Only two have responded as having had no contact with the family.

2.9 Seventeen have responded with information indicating some level of involvement with the family and have completed either an Individual Management Review (IMR) or a report. They are identified with an * in paragraph 2.6 above.

2.10 A summary of the facts obtained from IMRs, reports and from the family are as follows:

2.10.1 Adult M had started to drink at an early age and by the time she was 13 years of age she was drinking heavily. She became pregnant with her elder daughter after a short relationship with a boy from her school. She married three times, each time to men with alcohol problems, who subsequently abused her.

2.10.2 She had three children with her first husband. During the second marriage, all four of her children were taken into the care of Barnet Council Social Care because of the violence, substance misuse and alcohol problems within the marriage. Eventually she left her second husband and went to a Refuge in Wiltshire.

2.10.3 In August 2007 she met Adult R in a public house and married him in November 2007. Within three months he was arrested for assaulting her as a result of complaints by her elder daughter. During the marriage Wiltshire Police dealt with fifteen incidents of domestic abuse, thirteen of which Adult M was the victim. While they stayed in Norfolk for a short time, Norfolk police officers were called to four incidents. All of the incidents of domestic abuse were alcohol related. It is understood that there were many more occasions of domestic abuse which were not brought to the attention of support services. Adult M tried several times to reduce her dependency on alcohol and it was only when she stopped drinking for a short time that she tried to leave Adult R.

2.10.4 Throughout the IMRs there are details of the many actions taken by agencies and of their evident frustration that in spite of their actions and warnings Adult M would not leave Adult R. Her mother said she was more afraid of being on her own than she was of him.

Section Three: Key Issues

4.1 The DHR provided an opportunity to analyse information obtained from agencies and from family and friends; the Panel concluded there were no clear equality issues relevant in this case, other than perhaps Adult M being female, the following were key issues:-

- Adult M's lifestyle, her alcohol abuse and her refusal to leave Adult R.
- Adult R's binge drinking and his use of violence.
- The response of individual agencies to Adult R, Adult M and her family.

4.2 Adult M's lifestyle, her alcohol abuse and refusal to leave Adult R.

4.2.1 Adult M gravitated towards men, who like her father, were alcohol dependent. All three of her husbands were heavy drinkers, who when drunk were violent to her. She was often physically assaulted and learnt to use weapons to defend herself. Adult M suffered anxieties; self harmed and had suicidal thoughts according to her medical records.

4.2.2 During her final marriage she took steps to stop drinking for short periods of time, but as Adult R was also alcohol dependent and did not want to give up, she inevitably returned to drinking. It was during those periods of abstinence that she considered leaving Adult R only to later change her mind, in spite of the advice and offers of help from family and support agencies. The Review has details of a number of occasions when she decided to give him "one last chance"; going as far as asking for contact restrictions to be lifted.

4.3. Adult R's binge drinking and his use of violence.

4.3.1 The information available gives little detail of Adult R's life before he was made subject to a Community Order in 2008; although it is of note that he had no criminal convictions at that stage. He had been married twice before meeting Adult M and had four children (two to each previous wife) with whom he had no contact. There is no explanation of why these marriages broke down or why he did not have any contact with his children.

4.3.2 While Adult R was reluctant to acknowledge his violent behaviour to Adult M. In 2008 he did admit, in a Probation self - assessment, that drinking too much and losing his temper were the causes of his problems. It was on these occasions he was violent to Adult M. Agencies with which he was in contact identified his alcohol abuse as being a root cause of his violence to Adult M.

4.4 The response of agencies to Adult R, Adult M and her family.

4.4.1 The individual management reviews were thorough and honest in addressing each of the points in the Terms of Reference. The Review Panel gave careful consideration to each IMR, to ascertain if the agencies' interventions were appropriate and whether they acted in accordance with their set procedures and guidelines. Where they have not done so, the panel considered the lessons learnt (section four) and were satisfied that the proposed recommendations and action plan (appendix two) addressed them.

Section Four: Lessons to be learnt

5.1 The following agencies that had contacts with Adult R, Adult M or her family have identified lessons they have learnt from the Review.

5.2 **Avon & Wiltshire Mental Health Partnership NHS Trust (AWP)**

5.2.1 In relation to Adult M, she was offered timely and appropriate interventions in line with the evidence-base at the time. More recent NICE guidance advocates for more structured psychological interventions, and in 2011 SDAS began training all SDAS staff in the use of mind mapping – a structured CBT-based approach for working with substance misuse issues. This approach was not embedded in SDAS services until 2012/2013.

5.2.2 Since 2012, there has also been an increased emphasis on promoting and helping service users build 'recovery capital' through use of peer mentors, etc. This may well have proved useful to Adult M in making and sustaining lifestyle changes.

5.2.3 With regards to Adult M, there was evidence that her GP was provided with regular detailed updates; however in relation to Adult R, there was no evidence of written or verbal communication with any agencies. It is not known if this reflects actual practice or poor record keeping.

5.2.4 This case highlights the challenges of working with individuals with complex problems, where for example, both are drinking; there is domestic violence, possible co-dependency, stressful environmental triggers, long-standing problems with anxiety, depression and low self esteem, and poor coping mechanisms.

5.3 Kennet House Refuge

5.3.1 Since 2008, the Refuge has recognised the need for a more efficient way to maintain records than the ad hoc paper system previously used.

5.4 NHS Wiltshire CCG

5.4.1 It is acknowledged that contact time between a patient and GP is limited, but with a patient with a history of domestic abuse and an obvious current turbulent relationship, more information should be recorded.

5.4.2 As General Practice is the main point of contact for all priadult M healthcare services, GPs should have a holistic overview of their patients and their needs. The recognition of factors which, particularly in combination, may indicate that someone is experiencing or could potentially be harmed as a result of domestic abuse is very important. GPs need to be aware of the support services available to their patients

5.4.3 As the contact time that GPs have with patients is limited, it is important that they have a trigger list of indicators in the same way that they have for assessment of illness.

5.4.4 Whilst both public and professionals are often told that the Data Protection Act does not inhibit agencies from sharing information, it does not positively encourage or require it; nor, critically, does it explicitly offer protection to those charged with making the judgments about sharing sensitive personal

data in cases of suspected risk. (This is addressed in recommendation 7 of the new NICE Guidance on Domestic Violence and Abuse February 2014)

5.5 **Norfolk Constabulary**

5.5.1 On one occasion contrary to Force policy, a supervisor was not informed of the domestic incident by the Contact and Control Room (CCR).

5.5.2 Officers should not assume that the female is the victim in all cases of domestic abuse.

5.5.3 During one incident the parties were left together when there was an alternative arrangement which would have separated them.

5.5.4 Better records should have been kept in relation to Adult R's response when found by officers.

5.6 **Splitz Support Service**

5.6.1 Many service users prefer email or text contact, however, the importance of encouraging phone or face-to-face contact as early as possible is being emphasised.

5.6.2 Having a document retention period that was out of sync with other local agencies meant Splitz Support Service was unable to provide a shared history covering a six year period.

5.7 **Wiltshire Council Housing Management Department**

5.7.1 The housing file shows a lack of record keeping in relation to contact with Adult M who was the tenant. There are no records of visits to the property by the housing manager and the old filing system used separate systems to record housing management and repairs matters.

5.7.2 The first mention of domestic abuse was in a repair note in April 2008 where there was a request for a window to be boarded following a "domestic situation". This should have been a prompt to visit the tenant and make appropriate support referrals or take other actions in respect of safeguarding. There is no record of this action taking place, although a housing officer did attend the resultant MARAC and received a contact from the local police in relation to the incident.

5.7.3 All contacts with tenants are now recorded in the new housing management IT system.

5.8 **Wiltshire Crown Prosecution Service (CPS)**

5.8.1 Due to the Wiltshire Crown Prosecution Service file retention policy, the IMR Author was unable to trace the prosecution file of the case in April 2008

when Adult R was charged with common assault and false imprisonment. He has, therefore, been unable to identify any lessons learnt although he has made a pertinent recommendation.

5.9 **Wiltshire Magistrates Court Service**

5.9.1 The Wiltshire Magistrates Court Service records have not been retained for the above mentioned case in 2008, when, after representations from Adult R's solicitor, he was able to stay at the home address, with bail conditions that he did not visit Adult M's elder daughter's address, nor make contact with Adult M. It is therefore, not possible to identify what reasons were behind this decision or what lessons should be learnt.

5.10 **Wiltshire MAPPA**

5.10.1 A total of 14 actions were listed within the MAPPA minutes for agencies to complete. Despite this, the case did not remain a level 2 MAPPA case. Given the number of actions which were listed, there should have been a review meeting to evaluate the progress made by each agency before closing the case.

5.10.2 In light of the victim having children and the significant domestic abuse concerns, it would have been beneficial to have Wiltshire Children and Families at the meeting to provide their professional perspective on the case.

5.10.3 It appears from the MAPPA minutes that the "duty to co-operate agencies" were not in attendance at the meeting, although it is not clear if this was because they were not invited or failed to attend.

5.11 **Wiltshire MARAC**

5.11.1 MARACs have developed since this family was first referred to them and now routinely record the risks that are identified during the meeting. Where possible, the MARAC attempt to match actions against the risks.

5.11.2 The MARAC is not a statutory body and therefore cannot place controls on an individual, against their will.

5.11.3 The issue of whether Wiltshire Police should have been requested to issue an OSMAN warning was considered.

5.12 **Wiltshire Police**

5.12.1 Positive action in arresting Adult R for assaulting Adult M was generally taken by the officers that attended the various incidents.

5.12.2 There is a need to remind officers to carry out correct DASH risk assessments and to take a more robust approach to applying for DVPNs.

5.13 **Wiltshire Probation Trust**

5.13.1 In relation to dealings with Adult M it is not clear which agencies were contacted by the Pre Sentence Report (PSR) Author to assist with the completion of the report prior to sentence.

5.13.2 The supervision contact entries do not evidence all of the work which had been undertaken with Adult M in line with the Offender Assessment System (OASys) Initial Sentence Plan or subsequent reviews. The focus of supervision sessions had been on Adult M as the victim and there is no clear evidence of offence specific work having been undertaken in respect of her own offending behaviour.

5.13.3 The OASys was reviewed and Adult M's risk was reduced in July 2011 without there being evidence of this having been discussed with a line manager.

5.13.4 There is no evidence to suggest a referral to MARAC or MAPPA had been considered by the Offender Manager (OM) or discussed with a line manager.

5.13.5 There is no clear evidence of work having taken place with Adult M regarding her attitude about the use of violence and weapons. There is also no evidence of any victim awareness work having been undertaken.

5.13.6 The Offender Manager did not make a home visit.

5.13.7 With regard to contacts with Adult R, the supervising Probation Officer should have initiated contact with the Wiltshire Children and Families Department to investigate the position of Adult M's daughter and record this information in OASys as soon as he becomes aware of her.

5.13.8 At the start of both pre-sentence reports Adult R completed self-assessment forms where he listed what he considered to be his current problems. While most of these were addressed, his difficulties in managing money/dealing with debts were not. Financial problems can be a huge cause of stress and a referral to the Citizens Advice Bureau for advice should have been completed.

5.13.9 Greater care needs to be taken to ensure that probation risk assessments are consistent across MAPPA and probation records.

5.13.10 It is not clear what attempts were made by Probation staff at PSR stage, or afterwards, to get information about Adult R's previous marriages and lack of contact with his children.

5.13.11 After the custodial element of the Suspended Sentence Order (SSO) was activated in April 2009; Adult R had no further contact with WPT. He had been supervised for 12 months and a letter summarising the work he had

completed and some advice about agencies he might contact on his release may have been beneficial.

5.14 **IDVA Service Victim Support**

5.14.1 While contacts with Adult M were regular and supportive there were administration issues which need to be addressed.

5.14.2 The paper file contains all records of contact with Adult M and other forms of correspondence. Some documents were undated, and had no explicit author. These included the CAADA DASH risk assessment of May 2008 which is undated and unsigned, and there are no other file notes relating to this face to face visit and assessment. Nor is there a record of what advice or options Adult M was given.

5.14.3 Whilst the IDVA has been able to verbally confirm that fortnightly welfare telephone calls would have been made as a matter of routine, this is not documented in the records between July and October 2009. Nor is there evidence of regular case reviews, or of any file 'closing' consideration.

5.14.4 There was evidence of close working between the IDVA, Probation's Woman's Safety Worker and the police domestic abuse unit, but there is no recorded evidence of any individual safety and support planning.

5.14.5 There was a physical copy on file of a CAADA DASH risk assessment undertaken sometime around 6th and 11th May 2008, however there was no evidence of any subsequent risk review.

Section Five: Conclusions

6.1 In reaching their conclusions the Review Panel has focused on the questions:

- Have the agencies involved in the DHR used the opportunity to review their contacts with Adult R, Adult M and her family in line with the Terms of Reference (ToR) of the Review and to openly identify and address lessons learnt?
- Will the actions they take improve the safety of domestic abuse victims in Wiltshire in the future?
- Was Adult M's death predictable?
- Could it have been prevented?

6.2 The IMRs and reports in this Review have been detailed, open and questioning from the view point of Adult M. The organisations have used their participation in the review, to properly identify and address lessons learnt from their contacts with Adult M and Adult R in line with the Terms of Reference. There were little relevant contacts with Adult M's children, as

they were adults or in foster homes with only limited supervised contact with Adult M during her relationship with Adult R.

6.3 The Review Panel is satisfied that the agreed recommendations reflect the needs identified in the lessons learnt. Provided the action plans are properly and promptly implemented, they will improve the safety of domestic abuse victims in Wiltshire in the future.

6.4 The Review Panel, in considering all of the information provided, is of the opinion that Adult M's homicide by Adult R was predictable. In May 2008 a police officer completing a risk assessment answered "yes" to the question "Is the victim afraid the assailant will kill her"; Adult M's mother and three of her children warned her about the dangers on numerous occasions and gave evidence to that effect during the criminal trial. One son pointed out that he now has several convictions for violence, all related to trying to protect his mother from Adult R. Adult M was warned by an IDVA, a SDAS worker, police officers and probation officers about the continuing risk of violence from Adult R and this has been acknowledged by the family. Adult R was prosecuted, served prison sentences and was the subject of a number of interventions directed by the court and by the Wiltshire Probation Trust in attempts to change his offending behaviour. He recognised that when he was drunk he could be violent. However it was noted by the Panel that the murder itself was the only recorded incident in which Adult R had used a weapon.

6.5 The Review Panel when considering if the murder was preventable, are of the opinion that it would only have been preventable if Adult M had listened to the warnings given to her and had left Adult R. Family and agencies constantly warned her and she recognised the risks herself, but always wanted him back even to the extent of breaching court orders to be together.

Her mother and daughter both told the DHR Chair, she was more afraid of being on her own than she was of Adult R. Nevertheless the Review Panel notes that on the occasions that Adult M was alcohol abstinent she did consider leaving him. Sadly she inevitably returned to drinking and gave Adult R "one last chance".

Adult M refused the help offered and agencies and Adult M's family alike feel frustrated that they were not able to find any way of saving her without forcing her against her will to leave him. Adult M's elder daughter asked that it be stressed that the family accept that no one could have changed what happened to their mother; "as well as the family, a lot of people, particularly her alcohol counsellor, the police and probation tried really hard to get her to leave him". The family blame only Adult R for Adult M's death.