Wiltshire Domestic Homicide Review

EXECUTIVE SUMMARY

Into the death of Adult B on 5th September 2015

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1 Introduction

1.1. This Review examines the contacts agencies in Wiltshire had with Adult B (pseudonym) prior to her death on 5th September 2015. Adult B who was 55 years of age at the time of her death lived in Chippenham with her husband Adult P (pseudonym) who was 52 at that time.

1.2. The circumstances of Adult B's death are:

1.2.1. Both Adult P and Adult B were alcoholics, with life changing alcohol related illnesses. At the time of Adult B's death on 5th September 2015 both were known to be drinking heavily.

1.2.2. Adult P had spent the afternoon of the 4th September 2015 consuming alcohol with friends in a friend's home. He became argumentative and the friend took him home. Adult B came home at about 5pm and the friend left them. At 10pm Adult P went to a service station to purchase bottles of wine.

1.2.3. At 0615hrs on 5th September 2015 Adult P contacted the Ambulance Service to report that he was unable to wake Adult B. A paramedic attended and found her deceased with head injuries, the police were informed and following their attendance Adult P was arrested.

1.2.5. The Pathologist's report stated that Adult B's death resulted from complications of subdural haemorrhage caused by blunt force trauma to the head. Impairment of clotting due to cirrhosis may have exacerbated the haemorrhage. It was later stated that the fatal injury could have been caused Adult B falling off the sofa during the night.

1.2.6. A plea of manslaughter was accepted and on 16th February 2016 Adult P was sentenced to 6 years imprisonment reduced to 4 years due to an early plea of guilty.

2 The Review Process

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

2.2. On 13th October 2015 Wiltshire Community Safety Partnership took the decision to undertake a Domestic Homicide Review and on 14th October 2015 the Home Office was informed.

2.3. The process began on 2nd December 2015, with an initial Review Panel meeting of all agencies that potentially had contact with the victim, Adult B or the perpetrator, Adult P. Due to a request from the Senior Investigating Officer the Review was then adjourned until the conclusion of criminal proceedings, which were concluded on the 28th April 2016.

2.4. Adult B's mother and daughter were contacted at the commencement of the Review and agreed to sign a consent form for the Review to access Adult B's medical records. They also chose the pseudonym. Her mother wished to be kept informed about the progress of the Review and asked that any family contact should be through her in view of her granddaughter's age. Both Adult B's mother and daughter were informed about the dedicated support they could receive from AAFDA, however they said they did not need any further help, commending the quality of help they were receiving from the Police Family Liaison Officer and from the Homicide Service support worker. Nevertheless an AAFDA leaflet was left with them in case they changed their minds.

2.5. Adult P's solicitor was contacted by letter and by telephone. She agreed to speak to her client about the Review and to ask him for a pseudonym and for his consent for the Review to access his medical records. She eventually said her client was not in the right place mentally to consider anything. She was contacted after the conclusion of the criminal proceedings and agreed to speak to her client about having a visit from the DHR Chair and having involvement with the DHR. He declined.

2.6. At the conclusion of the Review Adult B's mother read the Overview Report, she commented. "I would like to thank the people on the Review for the care they have taken. We were very upset not just by my daughter's death but also by the sentence given out. Regardless of the way she lived, she did not deserve to die like that. I just hope some good will come out it for other people in her situation."

2.7. The agencies taking part in the Review are:

Avon and Wiltshire Mental Health Partnership NHS Trust

Bristol, Gloucestershire, Somerset, Wiltshire Rehabilitation Service (BGSW RS)

Doorway Project

Good Wellbeing Drop-in Centre

Great Western Ambulance Service

Great Western Hospitals NHS Foundation Trust

Royal United Hospitals Bath NHS Foundation Trust

Sovereign Housing

Splitz Support Service

Station Hill Baptist Church

Victim Support.

Wiltshire Anti-Social Risk Assessment Conference (ASBRAC)

Wiltshire Clinical Commissioning Group

Wiltshire Council Adult Care

Wiltshire Council Housing Allocations and Options

Wiltshire Council Revenues and Benefits

Wiltshire Police

Wiltshire Substance Misuse Service (Turning Point)

2.8. The agencies were asked to give chronological accounts of their contacts with the victim and/or perpetrator prior to the homicide. All relevant documentation was secured. Where organisations had no involvement, or insignificant involvement, they informed the Review accordingly.

2.9. Of the eighteen agencies contacted about this Review, seven responded that they had had no relevant contact with Adult B or Adult P. Eleven agencies completed an Independent Management Review (IMR) with information indicating some level of involvement.

3 The Facts

3.1 The facts obtained from the IMRs, the Pathologist and Adult B's family, friends and neighbours are summarised as follows:

3.1.1 Adult B had been in a ten year relationship with Adult P and they married in July 2013. They lived in Chippenham in premises owned by Sovereign Housing Association.

3.1.2 Adult B and Adult P had been heavy drinkers from their early twenties. Adult B started drinking after the death of her step-father and the suicide of her brother. Her first marriage ended because of her dependence on alcohol. Adult P's parents were both alcoholics and he started to drink heavily at University. He consequently dropped out during his second year.

3.1.3 By the time they met in 2005 they were confirmed alcoholics, both had had a number of detox therapies but each time had started drinking again. Each of them had serious alcohol related physical illnesses including cirrhosis of the liver. Adult B had difficulty walking and although she had extremely poor vision, she frequently relied on a wheelchair or mobility scooter to go out.

3.1.4 The first indication that Adult B might be the victim of domestic abuse came in 2007 when a housing officer noted that she had bruising, which she felt was not consistent when Adult B's explanation that she had fallen down. Subsequently an occupational therapist visited Adult B and a referral was made to Adult Care.

3.1.5 There followed a number of occasions when there were concerns that Adult P was controlling and agitated. Eventually in August 2010, Adult B did tell the Adult Care Team that Adult P had hit her the previous week. She said she had "wound him up" and that this was unusual behaviour. An offer of follow-up visits were made together with taking her to see her GP. Adult B said she would think about it. A month later during a home visit by a social worker, it was noted that "Adult P remained supportive but that their relationship has been volatile in the past. They have been physically aggressive with one another resulting in Adult B sustaining a black eye. They both 'laughed this off' giving the appearance they did not consider this domestic violence. Adult B agreed that she would contact her GP to make an appointment". No DASH risk assessment was made.

3.1.6 In November 2010 a paramedic was called to Adult B and found her "covered in bruises". Her carer, Adult P said it was caused by a fall, but when Adult B was on her own, she stated Adult P had dragged her around the room. Adult Care was informed and tried to contact Adult B who had a suspected stroke. Adult P was contacted and stated that they were both alcoholics and he could not cope with his needs as well as Adult B's. He said he did need support and he was allocated to a male social worker. When the social worker made an unannounced visit Adult P said to him, "You may think I hit her but I didn't. I'm not a violent person. She will tell you the same. I've a left a message for you and Adult B will phone you. I apologies if it seems a bit emotional. We like to keep to ourselves". Later the social worker spoke to Adult B. He explained that there had been a report from the ambulance service that she may have received injuries. She said this was incorrect. The social

worker asked if she had any concerns and several times she said she was fine. No DASH risk assessment was made.
On 18th February 2014 Adult P visited Wiltshire Housing, saying his marriage had broken down and asked for help with housing. He explained that he was the victim of domestic abuse from "his alcoholic wife" (Adult B). He was offered refuge accommodation but he refused this. No DASH risk assessment was made.

3.1.7 Adult P regularly visited the Doorway Drop in Centre and on two occasions, he confided in a member of staff, that he was subjected to domestic abuse by Adult B. He claimed to be very scared of her and that he realised that one day he might snap and hit her back. He spoke of a dilemma: If he leaves her then there is no one else to look after her, but if he stays then he is worried for his safety. He was given information about specialist support available from Splitz and from the police, but he said he did not want to get the police involved. On the second occasion, he said that Adult B was "abusive" and that it was time to leave her, since he was drinking too much and his liver couldn't cope. No DASH risk assessment was made. He was signposted to Wiltshire Council Housing where he was again offered a refuge placement. No DASH risk assessment was made.

3.1.8 In May 2014 Adult P reported to the police that Adult B had hit him with a pool cue following a drunken argument. A PPD1 was completed and assessed as standard risk. When police officers were speaking to Adult P at home two days later, Adult B returned in a drunken state and began shouting and swearing at Adult P. She was arrested to prevent a breach of the peace. The officers obtained information from Adult P in order to complete a PPD1, he stated that he was Adult B's carer, but did not feel able to fulfil that role. The police supervisor in checking the DASH risk assessment adjusted it to Medium from standard due to the increased number of calls to the address.

3.1.9 On 29th May 2014 Adult P contacted Splitz by telephone. His referral details were recorded as: "His wife is abusive when she is drunk. He called police and she is now staying at her Mum's. Adult B had been abusive to her previous husband, she glassed him in a public house. Adult P feels he cannot live like this any more, although he still loves Adult B. Adult P feels he does not want to resume the relationship, he is a recovering alcoholic and feels isolated". Due to increased demand and inadequate resources, it was not until 19th August 2014 that Adult P's case was allocated and telephone calls were made to Adult P on three separate occasions. After not receiving any replies; on 29th August 2014 the case was closed.

3.1.10 On the 15th September 2014 Adult P telephoned the police complaining that Adult B had locked him out, a PPD1 was completed with a DASH risk assessment of standard.

3.1.11 On 14th August 2015 it was agreed that as Adult B had gone back to drinking heavily for at least three months that her treatment from WSMS should stop but that she should attend non structured activities.

3.1.12 The police have no records of Adult B ever making any complains that Adult P had ever been violent towards her. Many of Adult B and Adult P's friends are heavy drinker by their own admission, and they all knew Adult P and Adult B to be heavy alcohol users. None claimed to have ever seen any physical violence between them

but one commented upon seeing Adult B “a few days before she died” covered in bruises.

3.1.13 Adult P told the two psychiatrists who interviewed him whilst he was in custody awaiting trial that Adult B was his greatest friend and soulmate; most of the time they were very happy together, but he acknowledged there was a dark side to their relationship. He said Adult B when drunk could be demonic, she would become verbally abusive, at times she would kick, punch and bite him.

4 Key Issues

4.1. The Review Panel, having had the opportunity to analyse all of the information obtained, consider the key issues in this Review to be:

4.1.1. **Adult B and Adult P's alcohol dependancy and resulting health problems**;

Adult B and Adult P's long term alcohol dependancy are detailed in section 3 of this executive summary. Over the years both had tried, on more than one occasion, to abstain but with no success. Their alcoholism resulted in both of them having serious physical health problems, including cirrhosis of the liver. On occasions, they both suffered from mental health problems including depression and anxieties. Adult B fell out of a third story window and sustained serious leg injuries which resulted in her often relying on a wheel chair or mobility scooter to go out. On two occasions she was arrested drunk in charge of the mobility scooter. Their GP felt that Adult B was the more serious drinker of the two and that Adult P would have been more successful in stopping drinking if there had been no alcohol available it the house. Adult P himself stated that he found it impossible to refrain from drinking when Adult B was still drinking and had alcohol in the house. When sober, Adult P made efforts to stop Adult B going out to buy alcohol, but twice, this resulted in Adult B telephoning the police alleging he was unlawfully detaining her in the house.

4.1.2. **Adult B and Adult P's domestic abuse towards each other**.

Adult Care, Doorway, Sovereign Housing, Splitz, Wiltshire Housing, Wiltshire Drug and Alcohol Service and the Police were aware that there was domestic abuse occurring between Adult B and Adult P. Although there were occasions between 2007 and 2010 that Adult B admitted that Adult P had assaulted her, she made light of it saying it was only when she "wound him up". However after she stopped the support she had been receiving from the social workers and occupational therapist in 2010 she never confided in anyone about Adult P's violence. Adult B's mother told the Review that she suspected that Adult P was violent as Adult B was often covered in bruises, however Adult B always denied he hit her, explaining the bruises as having been caused by falling down while drunk. Adult B's GP never probed, as he assumed her injuries and bruises were due to her falling while drunk or due to the loss of feeling in her feet. Two days before her death, he asked how she injured her foot and she claimed not to remember as it had happened when she was drunk. Adult P, on the other hand, informed several agencies that he was a victim of domestic abuse. Other than the police, agencies gave no consideration to completing DASH risk assessments or making referrals to specialist domestic abuse support services.

4.1.3. **Whether Adult P being male, influenced the manner in which agencies responded when he claimed he was a victim of domestic abuse**.

As Adult P told a number of agencies that he was being subjected to domestic abuse from Adult B, the Review considered if being a male victim adversely affected the support he received.

- Adult P contacted the police about Adult B locking him out of their home and this was properly recorded as domestic abuse and a supervisor later reviewed the level of risk due to the number of incidents.

- On another occasion he contacted Splitz (domestic abuse support service) complaining that Adult B was abusive to him when she was drunk. It was 11 weeks before a support worker unsuccessfully tried to contact him, but the Review is satisfied that this was due to a general lack of resources rather than him being male.

- There were two instances when Adult P told a worker at the Doorway Drop-in Centre that Adult B was violent towards him and that he feared he might one day react violently. On the first occasion it was suggested that he contact the police but he refused, on the second occasion he was referred to Wiltshire Housing.

- Twice he made contact with Wiltshire Housing and informed them he was a victim of domestic abuse. On both occasions he was offered refuge accommodation, which he declined, there was no DASH risk assessment completed.

- Adult P received treatment from the Wiltshire Substance Misuse Service between 22nd September 2014 and 26th January 2015. During the first risk assessment, Adult P had stated that there had been domestic violence from his wife and that the police had been called on a few occasions. The second was completed on 31st December 2014 and there was no indication of any current risk of violence. The last review with him was on the 20th January 2015 where he reported continued abstinence and said there was a demonstrable improvement in the relationship with his wife. WSMS has a domestic abuse policy which staff are aware of and follow, however in Adult P's case it was understood that the abuse from Adult B was historic and the police had dealt with it. There was no indication that Adult P being male influenced the manner in which he was dealt.

4.1.4. **The delay in responding to Adult P's request for support from Splitz, the Wiltshire commissioned domestic abuse support service**.

- Splitz is a well-established service provider, but at the time Adult P contacted them in May 2014 the service was experiencing a high demand for services (an increase of 63% referrals from Chippenham and 21% across all of Wiltshire). This resulted in long waiting times before cases were allocated to a support worker. In this case a support worker wasn't allocated for just over 11 weeks. By the time a support worker tried to contact Adult P, he did not respond and his case was closed.

- Since this incident Splitz has introduced a referral triage system, which provides initial support and /or signposting, but there are still delays of 8 weeks or more before a victim is contacted by a support worker. As a result of this being highlighted in this Review Wiltshire Community Safety Partnership is organising an urgent meeting with other agencies (including police Probation, CCG and Army) that refer victims to Splitz to address funding and other capacity issues. Splitz is already in the process of exploring other funding raising opportunities.

5 Lessons to be Learned

5.1. The following agencies that had contacts with Adult B and/or Adult P have identified effective practice or lessons they have learnt during the Review.

5.2. **Doorway**

5.2.1. Doorway did not have a separate organisational Domestic Violence Policy.

5.2.2. There is a need for a clear and defined process for follow up work, (including contact to be made with specific external specialist agencies) to be carried out by staff, after concerns have been expressed relating to threats or worries about violence.

5.3. **South Western Ambulance Service NHS Foundation Trust**

5.3.1. Since the 10th November 2010 incident, there have been changes within adult safeguarding practice within SWASfT. It was recognised that there were logistical barriers to the sharing of information between clinicians and other agencies. The use of the Control Room staff to fax referrals to Social Care dictated by clinicians by telephone was a reasonable solution at the time in 2010.

5.3.2. Safeguarding referrals are now generated through internal forms and are triaged and processed through a dedicated safeguarding team. In some regions using the new electronic patient records, these forms can be submitted directly from the tablet used in the field. The triage team then review each referral and redirect to appropriate agencies using secure email facilities. Under current practice, this referral would be referred to the patient's GP practice and the Police as well as to Social Care. It should be noted that this is not common practice across the UK. Only SWASfT and one other service employ a safeguarding referral triage system. SWASfT currently generate in excess of 1000 safeguarding referrals per month. The SWASfT region covers 7 counties and currently 768 GP practices. It is doubtful that the infrastructure in 2010 in GWAS could have supported a safeguarding referral triage system of this design.

5.3.3. A lesson can be learned retrospectively from review of this incident that there remains value and notable good practice in the employment of an internal safeguarding referral triage and processing system within SWASfT.

5.4. **Sovereign Housing Association**

5.4.1. The Housing Officer who made the home visit in April 2014 did not adhere to Sovereign Housing's Safeguarding or Domestic Abuse policies. Any situation that an officer comes across where a resident has unexplained injuries/bruising or there is damage to the property should have been raised with the appropriate organisation through the correct channels.

5.5**. Splitz Support Services**

5.5.1. The 11 week waiting time to receive a service was not acceptable. Prior to the spike

in demand across Wiltshire and specifically in Chippenham, Splitz did not have the capacity to meet demand in a timely manner (they were operating an eight week waiting time) and this spike led to even greater waiting times.

5.5.2. A dedicated referral triage system would have enabled Splitz to better assess the risks in this case. Such a dedicated referral triage team would have been able to provide initial support and/or signposting. They would also have been able to maintain more frequent contact with cases that have not yet been allocated, monitoring risk and reassessing need.

5.7. **Wiltshire Clinical Commissioning Group**

5.7.1. The Review has shown that record sharing by all clinical agencies may reduce the risks of this type of incident.

5.7.2. Wiltshire CCG needs to ensure all Wiltshire GP practices have an awareness of safeguarding and domestic abuse issues.

5.8. **Wiltshire Council Adult Care**

5.8.1. Observations on a client's file must include clarification on matters of capacity and record the outcome of a safeguarding alert and the feedback given to the original referrer.

5.8.2. At the time there was a need for training on the use of the Mental Capacity Act, this was subsequently put in place and is no longer an issue.

5.8.3. The Care First data base did not require the recording on feed back to alerters, this is now in place.

5.9. **Wiltshire Council Housing**

5.9.1. Staff should follow up advice provided to clients about support agencies with appropriate referrals to those specialist services.

5.9.2. Housing staff need to better understand safeguarding triggers and how issues / concerns should be reported.

5.9.3. A requirement for housing staff to better understand the importance of safeguarding and attending regular annual training.

5.9.4. Improved understanding of what agencies are available to assist those fleeing domestic abuse

5.10**. Wiltshire Police**

5.10.1. Police officers in dealing with Adult B and Adult P were faced with difficult situations as it was often very difficult to reason with them due to their extremely drunken state. On the occasions when Police officers attended at their flat, positive action was taken in removing Adult B from a volatile situation and taking her to her mother's home. Positive action was also taken in arresting Adult B in order to

remove her temporarily from the family home in order to gain some breathing space.

5.10.2. As of the 1st January 2016 Horizon, the witness care unit at Wiltshire Police telephone victims of domestic abuse that have been identified as standard risk and signpost them to appropriate support agencies as required. This was an area that had been identified as requiring attention as medium and high risk cases are supported by the Domestic Abuse Investigation Team whereas standard risk cases are generally not.

5.11. **Wiltshire Substance Misuse Service (WSMS)**

5.11.1. The wording on the WSMS assessment form does not specify domestic abuse.

5.11.2. Currently when partners are in treatment their risk assessments are not cross referenced.

5.11.3. Past risks are not always followed up.

6 Conclusions

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

- Have the agencies involved in the Review used the opportunity to review their contacts with Adult B and/or Adult P in line with the Terms of Reference of the Review and to openly identify and address lessons learnt?
- Will the actions they take improve the safety of Wiltshire domestic abuse victims, particularly those with alcohol issues in the future?
- Was Adult B's death predictable?
- Could Adult B's death have been prevented?

6.2. **Have the agencies involved in the joint Review used the opportunity to review their contacts with Adult B and/or Adult P in line with the Terms of Reference (ToR) of the Review and to openly identify and address lessons learnt?**

The Review Panel acknowledges that the Individual Management Reviews and other reports have consistently been thorough, open and questioning from the view point of Adult B and Adult P. The Panel is satisfied with the evidence provided by those organisations that have shown that their contacts with either Adult B or Adult P were in accordance with their established policies and practice and that they have no lessons to learn. Other organisations have used their participation in the Review to properly identify and address lessons learnt from their contacts with Adult B or Adult P in line with the Terms of Reference.

6.3. **Will the actions they take improve the safety of Wiltshire domestic abuse victims, particularly those with alcohol issues in the future?**

The Panel is satisfied that the implementation of the recommendations made within the Review will address the needs identified from the lessons learnt and make life safer for Wiltshire victims of domestic abuse, particularly those with complex needs due to alcohol problems. Nevertheless the Panel records its concern that the Splitz Domestic Abuse Support Service does not have the capacity to meet the ever increasing demand for services. This must be urgently addressed by Splitz and local commissioners.

6.4. **Was Adult B's death predictable?**

There was one occasion in 2014 when Adult P confided in a worker at the Doorway drop in centre that he was worried he might react to Adult B's abuse towards him. The worker who was experienced, did not think it was a serious threat as she heard such comments previously from the drop-in centre guests and also as Adult P made it clear he cared about Adult B and could not leave her. Other than this incident there was little indication that Adult P might seriously harm Adult B. After 2010 no agency had any record of Adult B reporting any violence from Adult P

The Review Panel is therefore satisfied that agencies had no grounds to predict Adult B's death by violence from Adult P.

6.5. **Could Adult B's death have been prevented?**

The few times Adult B admitted that Adult P hit her were to a social worker and occupational therapist in 2010. After that time, she claimed to her mother, friends, and agencies that her bruises were from falling whilst drunk. Even when she had a black eye, she told her mother and friends that Adult P never hit her, Adult P however did tell a number of agencies that Adult B abused when she was drunk. Whilst in custody he reiterated this in detail to two psychiatrists.

Both Adult B and Adult P were drinking heavily at the time of her death and both had stopped receiving treatment from WSMS. In 2014 Adult B had told Wiltshire Adult Care that she no longer wanted to see a social worker or an occupational therapist, so with the exception of her GP, she was no longer receiving any outside support. She did go to her GP surgery on 4th September 2015 regarding a small haemorrhage in her left eye and while there showed the GP her left foot which she said she had injured while drunk, she said she had no idea how it had happened. This was the norm for Adult B, her GP often saw bruising on her and when he asked her about them, she would reply that she had sustained them while drunk and could not remember. She never made any suggestion to the GP that Adult P had been violent to her and the letters send to the GP Practice from other agencies never referred to concerns regarding domestic abuse. The GP was satisfied that the various bruising he saw on Adult B were consistent with her falling, which she was prone to do whilst inebriated due to the loss of feeling in her feet.

Adult B and Adult P's circle of friends were primarily people with alcohol related problems themselves, who did not recognise the significance of the bruising on Adult B. Only one friend mentioned Adult B's bruising to the Review. She said, "I noticed that (Adult B's) arms were both covered in bruises from the elbow to the shoulder. I noticed that the bruises were of different colours, black, blue and green. My thoughts on seeing (Adult B) that day was "Oh my God look at the state of you". I was so shocked. I really did not know what to do and felt there was nothing I could do." Adult B never told her how she got the bruises. That was the last time she saw her.

Adult B was a very private individual, intensely loyal to Adult P, never sharing her feelings nor seeking help for the abuse she was suffering. Over the last twelve months of her life, sadly Adult B was perceived by neighbours, friends and agencies as being almost constantly inebriated; consequently her injuries were too easily written off as being a result of her heavy drinking.

6.6 The Panel has concluded that whilst there are clear lessons to be learnt, no agency had sufficient information to have enabled them to take action which may have prevented Adult B's death.