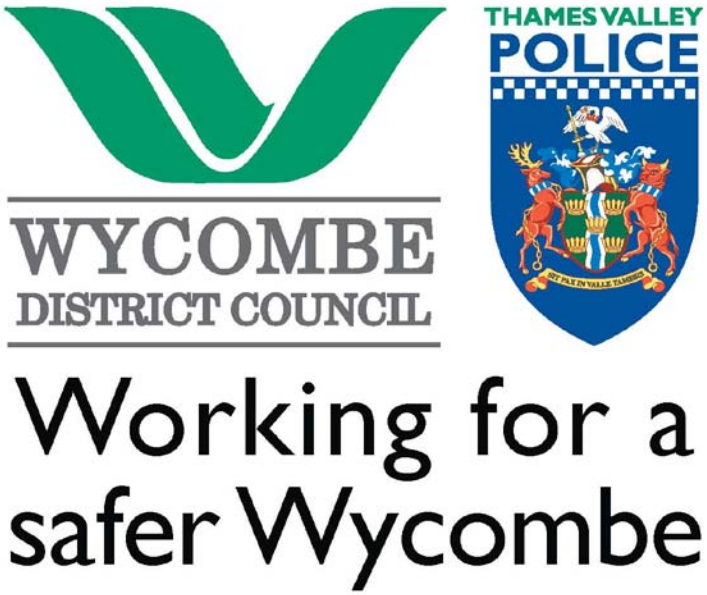

Domestic Homicide Review
Executive Summary

REPORT INTO THE DEATH OF ADULT A ON 4th January 2012

Report produced by Liz Hutton:
September 2012

DOMESTIC HOMICIDE EXECUTIVE SUMMARY

1. Introduction

This Domestic Homicide Review (DHR) examines the circumstances surrounding the death of Adult A on 4th January 2012 in Wycombe District. Thames Valley Police were called to a domestic incident on 3rd January 2012 by the perpetrator. Adult B has been found guilty of the murder by strangulation of Adult A and sentenced to a minimum term of 14 years imprisonment.

2. The review process

This summary outlines the process undertaken by the Domestic Homicide Review Panel in reviewing the murder of Adult A. It was commissioned by the Wycombe Community Safety Partnership in response to the death of Adult A on Tuesday 4th January 2012.

3. Terms of Reference

Purpose of the review

The purpose of the review is to:

- Establish the facts that led to the incident in January 2012 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the victim of the homicide.
- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.
- Establish whether the agencies or inter agency responses were appropriate leading up to and at the time of the incident in January 2012.
- Establish whether agencies have appropriate policy and procedures to respond to domestic abuse and to recommend any changes as a result of the review process.
- Domestic homicide reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

Scope of the review

The review will

- Seek to establish whether the events of January 2012 could have been predicted or prevented.

- Consider the period of one calendar year prior to the events, subject to any information emerging that prompts a review of any earlier incidents or events that are relevant.

- Request Internal Management Reviews by each of the agencies defined in Section 9 of the Act, and invite responses from any other relevant agencies or individuals identified through the process of the review.

- Seek the involvement of the family, employers, neighbours and friends to provide a robust analysis of the events.

- Take account of any Court action in terms of timing and contact with the family.

- Produce a report which summarises the chronology of the events, including the actions of involved agencies, analyses and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.

- Aim to produce the report by 4th July 2012, subject to responding sensitively to the concerns of the family, the internal management reviews being completed and the potential for identifying matters which may require further review. **Note: a request was sent to the Home Office on 30th May 2012 asking for the date to be extended as IMRs were still awaited. In addition the trial at Reading Crown Court was not scheduled until 2nd July 2012; liaison with family and friends could not be attempted before completion of the trial. (Response to request to extend received after 3 weeks).**

Expert witnesses and advisors

It is intended to consider consulting with the following agencies and individuals to provide a view of the findings and recommendations arising from the report.

- Buckinghamshire Primary Care Trust
- Buckinghamshire County Council
- Wycombe District Council
- Thames Valley Probation Service
- Thames Valley Police
- Local Domestic Abuse Service Providers
- Buckinghamshire Adult Safeguarding Board
- Buckinghamshire Children's Safeguarding Board
- Red Kite Community Housing (includes Wycombe District Council files)
- Adult A's Family
- Adult B's Family
- Adult A's GP
- Any Employer

- Local voluntary services – including drug treatment agencies and local Rape Crisis

Other appropriate agencies and people may be identified through the course of the review.

Finalised on 28th March 2012.

Process
All agencies that had been involved with the family over previous years were asked to contribute to the review and where appropriate to provide chronologies and Individual Management Reviews if required.

Chronologies
Chronologies have been provided by Thames Valley Police, Red Kite Housing, NHS Bucks, Safeguarding Team, Education and school attended by the children, and Youth Offending Service.

Individual Management Reviews (IMRs)

IMRs were requested from Thames Valley Police and Red Kite Community Housing. Red Kite took over the management of the housing stock from Wycombe District Council in 2011 but records have been available to the new company. IMRs were received on Friday 6th July and Thursday 5th July 2012 respectively. Both of the IMRs gave full and adequate information. The Thames Valley Police IMR was extremely detailed giving a full picture of records going back many years. The Red Kite IMR contained varying levels of detail but all was relevant and helpful. As a Panel we reviewed both IMRs and returned to their authors for clarification on various points until we were satisfied.

Panel Members
The members of the Panel are as follows:

Representative FOR:	**NAME**	**POST**
Red Kite Community Housing	Martyn Hale (IMR author)	Director of Neighbourhood Services
Bucks CC Safer Bucks Partnership Manager	Susie Yapp	Managing County Community Safety matters, the Drug and Alcohol Action Team and undertaking the partnerships role in Thames Valley Police
Wycombe District Council Community Safety Partnership	Gillian Stimpson	Community Safety Manager

Thames Valley Police	Christopher Inniss	Detective Inspector, Protecting Vulnerable People Manager Buckinghamshire Hub
Thames Valley Police	Jill Morton (IMR author)	Detective Constable, for the Major Crime Investigation Review Team
NHS Buckinghamshire	Tania Atcheson	Designated Nurse Child Protection
Wycombe Womens Aid	Lisbeth Harvey	Director
Wycombe District Council	Kiran Khanna	Principal Solicitor, Litigation & Contract Section Democratic,Legal & Policy Section
	Liz Hutton (Report author)	Independent Chair

Independent Chair

Liz Hutton was appointed in February 2012 to chair the panel as an independent person not attached to any of the agencies involved in the review. She has experience of the local community, the legal system and the voluntary sector having served in excess of 30 years as a school governor, and 25 years as a magistrate. In these capacities she has undertaken extensive training in Child Protection and Safeguarding. As a magistrate she served in the Adult Criminal Court and Youth Courts where relevant and regular training was completed especially including Domestic Violence and related criminal activity, and sentencing of perpetrators. Other relevant voluntary work included Community Safety and Youth work. At no time has she been employed by, or worked for any of the agencies involved in the review.

4. Key issues arising from the review

There is evidence of domestic violence by Adult B on Adult A over a period of 5 years from 2002 up to 2007, when on more than one occasion he strangled her with his hands. After that period there were no contacts of any relevance with agencies.

- In 2002 and 2003 domestic abuse took place but the victim later withdrew statements so he was not prosecuted.
- Constant level of mental and verbal abuse over the 5 year period.
- Violence shown by Adult B towards others including friends, neighbours and the staff of the Housing Department.
- Successful prosecution in 2006 of Adult B but the convictions were overturned on his appeal in 2007 to the Crown Court in the absence of the victim and the perpetrator.

- Adult A was treated for depression and anxiety attacks between 2001 and 2006; and on one occasion she was referred by the GP to the Community Mental Health Team as having suicidal tendencies, but declined the service.

Although much of the recording of the Domestic Violence by Thames Valley Police was thorough and robust at the time, there were some "missed opportunities"

- Failure to refer case on to Safeguarding and other agencies for support to improve the safety of Adult A and their two children;
- Failure to arrest Adult B for offences and breach of bail conditions.
- Lengthy delays in dealing with allegations which did not follow the guidance of 2004 to deal with domestic incidents swiftly to protect the victim.
- The children were present during most of these incidents yet only on one occasion were they referred to Safeguarding. Whilst it seems agreed Adult B was never violent towards the boys, they were frightened when he was angry and hid in a cupboard.

Since those times, many changes in practise have taken place, plus training of officers to specialise in dealing with domestic incidents.

There has been a long involvement with the family with Wycombe District Housing (now Red Kite Community Housing). In the main the involvement has been related to the tenancy and any issues relating to repairs and improvements required to the property.

- Early signs of Adult B's behaviour were identified in 2001 when threats were made to staff, however the documentation was spasmodic and lacked any coordination.
- Continued threats to staff resulted in an Anti Social Behaviour Order in 2004.

During 2005 – 2006 Adult A took out court injunctions to prevent Adult B from having contact with her. Adult A moved out of the area and away from Adult B for about 6 months; there was a 2 year period with no evidence of any issues between the couple, although Adult A did move back to Adult B. Adult A and Adult B were married on 26th October 2008. From this date until the death of Adult A there no record of either person being significantly involved with any agencies.

5. Feedback from Family and Friends

The panel delayed contact with the family and friends until after the outcome of the trial and sentencing of the perpetrator. Through the Family Liaison Officers we have learned the immediate family are unwilling to meet and discuss the events leading up to the homicide and we respect their wishes recognising the sensitivity of the situation. However, the victim's mother has agreed to release a copy of her statement made to the police. There has been no contact with the family of Adult B. Contact has been made with friends of the couple and work colleagues; in addition

all have agreed to the release of their statements made to police. These together with telephone conversations have confirmed the long history of abuse by Adult B, and that Adult A believed he would change. The mother of Adult A believes there may have been opportunities to give the family more support if Social Services had been involved; this would have been particularly relevant for the two children as they were bullied by their father.

6. Lessons to be Learned

i) Sharing of information between all agencies in early times seems to have been limited. Referral from one agency to another was mentioned but not completed. Housing was aware of the violent nature of Adult B but did not refer to Social Services or Child Protection in spite of knowing young children were present in the property.

ii) Reporting of incident involving one son in a sexual assault of a girl under age13 years was not reported to Children Social Care. Youth Offending Service was involved but this was not reported to Safeguarding. The information was not included when consideration was given to a Serious Case Review. Whilst in itself it is not relevant to the domestic homicide review, it may be an indication of the impact of repeated domestic violence issues within the household on the children and highlights the need for better interagency communication.

iii) The role of the universal services provided by health, education and early years' provision is crucial to addressing issues associated with safeguarding children and young people from domestic violence. Professionals need to become more aware of the power of their role, and to use it to safeguard children and to support parents experiencing domestic violence. It is vital that all professionals undertake a complete assessment including asking questions about relationships and the home environment so that issues can be picked up at an early stage.

iv) It is vital that all agencies communicate with each other to identify families where domestic violence is a concern, share their information and expertise to ensure there is a co-ordinated plan to support the vulnerable people involved. Early intervention must be far more cost effective than waiting for the crisis that results in irreparable damage, especially to the children caught up in the household.

v) General awareness of domestic violence has improved over recent years but there is still more work to be done in encouraging everyone to recognise the signs and take responsibility for supporting victims with the help of statutory and voluntary agencies. Regular training and robust systems for monitoring

referrals need to be in place to ensure no one is overlooked or slips through the net.

7. Conclusions

The first and most important conclusion from the review is that there is no indication from the evidence provided in the Individual Management Reviews that any agency had any knowledge of any domestic violence between Adult A and Adult B since 2006 up to the homicide in 2012. From 2002 to 2007 much of the work done by Thames Valley Police, Police in Cumbria, and in Scotland has been thorough and well intentioned. Areas of concern have been highlighted in their recommendations, but it must be acknowledged that many of these have already been addressed since in any event, either through similar reviews, or through more modern developments and practice. The Review Panel set out to seek to establish whether the events of January 2012 could have been predicted or prevented. From all that we have learned we feel there is no way that any agency could have predicted or prevented it since there had been absolutely no relevant contact with any agency during the year leading up to January 2012.

The Red Kite Community Housing has listed the Lessons Learned and Recommendations which indicate improved methods of working with such aggressive individuals and better protection for the victim and families in Domestic Violence settings with referral to Safeguarding and to support agencies. It is clear that throughout the involvement of the housing agency, the action taken was reactive rather than pro-active.

The DHR Panel has recognised the value of these reviews as a way of checking and verifying processes and their effectiveness.

8. Recommendations

8.1 Red Kite Community Housing

Recommendations

It is important in the widest sense that RKCH commit representatives to the local crime and disorder partnership, MARAC and other forums in a consistent manner and feedback be provided. In particular it is recommended that RKCH:

1. Provides clear advice and guidance to its staff on how the recording of conversations and general notes are made, which includes specific awareness training in relation to managing aggressive clients; ensures property files are audited more frequently to make sure the standard of note taking and record keeping is appropriate;

2. Ensure the clear lines of communication are established between agencies to make sure the flow of information takes place; ensure that information exchanges between the council and RKCH are clear and a review mechanism is in place;

3. Review its approach to risk management and ensure that all staff receive clear training and guidelines to help manage risk; identify a lead for the case; management of potentially violent and threatening tenants; review its approach to Safeguarding for its staff;

4. Publicise more widely to front line staff the protocols that exist for domestic violence and offer basic awareness training in partnership with Wycombe Women's Aid; RKCH commit to the domestic violence forum;

5. Review its methods for data storage to ensure records are kept in chronological order and secure where necessary; ensure reporting systems are better managed and linked to other systems clearly.

8.2 Thames Valley Police

Recommendations

1. TVP to conduct an audit of a number of High Risk domestic abuse initial investigation plans to ensure these are comprehensive and are in line with current guidance.

2. That guidance be issued to all TVP staff reinforcing the need for them to amend suspect's bail prior to them attending the Police Station to answer this in order to resolve the legality issue identified by the TVP Head of Legal Services.

3. That the TVP Bail Standard Operating Procedure (SOP) be updated to ensure Custody Officers are booking suspects in to Custody who attend Police Station to answer their conditional bail. This should only be in exceptional cases and will bridge the legal gap identified by the TVP Head of Legal Services.

4. That guidance be issued to all TVP staff reminding them of the need to arrest suspects in domestic abuse cases where any breach of bail is identified, irrespective if the victim allowed/facilitated the contact.

5. That all staff are reminded that PNC wanted markers should be considered in all High Risk cases where the offender has not been immediately arrested.

6. That the court appeal process is reviewed at the next multi-agency PVP steering group to ensure procedures adequately meet the needs of domestic abuse victims and that OICs are advised of the timing of these well in advance. This should ensure a process is in place to follow up all victim non-attendances.

8.3 Recommendations from DHR Panel

Recommendations

1. Create a comprehensive list of contacts to be made in the incidence of a Domestic Homicide to prevent delay in securing files. This will formalise the process and speed up reaction if the correct lead person for each possible agency is identified easily.

2. The Home Office should enable cross-border sharing of information. Whilst only one incidence of lesser importance occurred in this review, it could pose a huge problem in the future.

3. The Wycombe District Council Housing Options should ensure that a representative attend the Domestic Violence Forum to share guidance with all local housing providers including the smaller ones.

4. Bucks County Council to ensure all agencies have DVA training on a regular basis.

Executive Summary completed on 23rd September 2012 (further changes made following HO recommendations January 2013).