Safer Somerset Partnership

Domestic Homicide Review

Executive Summary

Into the death of Ms A (pseudonym) on 30th September 2014

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Independent Domestic Homicide Review Chair and Report Author

Report Completed: 31st March 2016

1. Introduction

1.1. This DHR examines the circumstances surrounding the death of Ms A (pseudonym) who was 57 years of age and lived in Taunton, Somerset.

1.2 Ms A was a single lady. She was described, by key witnesses to the police, as someone who 'was well organised, had a laid back view of life, and was a very private person'. She had one child Mr B born in 1987.

1.3 Ms A lived with the child's father until separating when Mr B was about 3 years old. Mr B's contact with his father was sporadic as he grew up. In 2010, Mr B moved to Whitstable, Kent where his father was living. In Whitstable, Mr B met his first girlfriend, Miss C, seemingly his first serious girlfriend.

1.4 In April 2014, Mr B and Miss C split up and in June 2014 he moved back to Taunton from Whitstable. He told friends he was going to visit his mother and grandparents. In July 2014 he secured employment in Taunton and said he would be staying in Somerset from now on. He was living with his mother in a two bedroom house in Taunton, Somerset.

1.5 **Incident summary:**

1.5.1 On 29th September 2014, Mr B went to work on a wine tasting and training day. He consumed a considerable amount of wine by his own admission, but was capable of holding lucid conversations and did not appear, to those who observed him to be very drunk. He also obtained and took cocaine after returning home at about 11.30pm.

1.5.2 Between approximately 11.30pm and 4.45am Mr B sexually assaulted and murdered his mother by ligature strangulation (flex around the neck). At 4.45am he fled the property by driving his mother's car. He first drove to the nearby supermarket to purchase a bottle of rum using the self-service checkout. It is known that he had been drinking the bottle of rum whilst driving. He then drove towards Exeter, Devon.

1.5.3 Later that morning Mr B was involved in a road traffic accident turning the car onto it's roof. Mr B continued his journey by foot and then entered a nearby property uninvited and was shortly afterwards arrested for suspicion of burglary. Whilst in police custody he was also arrested for driving whilst unfit, through the use of drink and drugs, and taking a vehicle without consent.

1.5.4 Meanwhile, concerns were raised in Taunton as to Ms A's welfare because she had not attended work that morning. At approximately 8.25pm that day, police officers attended Ms A's address and entered the property via the front bedroom window using a ladder to find Ms A dead.

1.5.5 Whilst in police custody Mr B was arrested on suspicion of rape and murder of Ms A, his mother. His reply was 'that's a bit of a shock'.

2. The Review Process

2.1 The key purpose of undertaking this DHR is to enable lessons to be learned from Ms A's death. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened, and most importantly, what needs to change in order to reduce the risk of such a tragedy happening in the future.

2.2 The Review considers all contacts/involvement agencies had with Ms A and Mr B during the period 30th September 2010- 30th September 2014, as well as any events, prior to 30th September 2010, which are relevant to mental health, violence and abuse.

2.3 The DHR Panel consists of senior managers, from both the statutory and voluntary sector, listed in section 2 of this report. All of the organisations who have been part of the Review have assisted in the identification of lessons and committed to implementing action plans to address the lessons. None of the members of the panel or the Individual Management Review Author for one of the organisations have had contact with Ms A or Mr B prior to the homicide.

2.4 Expert advice has been sought for this Review by a number of individuals two of which have been Panel members, these include, Marilyn Selwood from Somerset Integrated Domestic Abuse Support Service regarding the delivery of specialist domestic abuse support services in the Somerset area and Rowan Miller from Somerset and Avon Rape and Sexual Abuse Support regarding advice on sexual offences and the typology of offenders. Alex Chapman from Turning Point the specialist provider for Drug and Alcohol support services also provided expert advice to the panel this was with regards to Mr B's use of drugs, including NPS (new psychoactive substances otherwise known as legal highs), and alcohol and their impact on behaviour.

2.5 The agencies participating in this Domestic Homicide Review are:

- Safer Somerset Partnership
- Somerset County Council
- Somerset Partnership NHS Foundation Trust
- Somerset Clinical Commissioning Group
- Avon and Somerset Constabulary
- Knightstone Housing (SIDAS- Somerset Integrated Domestic Abuse Service)
- Somerset and Avon Rape and Sexual Abuse Support (SARSAS)
- Turning Point (SDAS- Somerset Drug and Alcohol Service)
- Canterbury and Kent Clinical Commissioning Group

2.6 During the preparation of this report the Independent Chair approached the victim's family and employer as well as Mr B in prison via letter together with a copy of the Home Office leaflet. Unfortunately, none of these individuals responded to the

invitation to be part of the review. The Independent Chair was also engaged with the Family Liaison Officer who had a positive relationship with the family, who advised that they did not wish to be involved in the review. The Independent Chair also approached the charity AAFDA (Advocacy After Fatal Domestic Abuse) to find out if the family had engaged with this service and wished to be involved in the review through their victim caseworker- unfortunately this charity had not had any contact with the family either. Nevertheless, the DHR Chair has consulted with Mr B's ex partner Miss C.

2.7 On completing this report, Miss C was advised of the lessons learnt and recommendations of this review.

3. Domestic Homicide Review Panel

Faye Kamara LLB, MSc- Independent Chair

Suzanne Harris, Somerset County Council

Marilyn Selwood, Knightstone (SIDAS- Somerset Integrated Domestic Abuse Service)

Rowan Miller, Somerset and Avon Rape and Sexual Abuse Support (SARSAS)

Julie MacKay, Avon and Somerset Constabulary

Julia Hendrie, Somerset Partnership NHS Foundation Trust (SomPar)

Richard Painter, Somerset Partnership NHS Foundation Trust (SomPar)

Mike Williams, Avon and Somerset Constabulary

Gill Munro, Somerset Clinical Commissioning Group

Mark Edginton, Avon and Somerset Constabulary

4. The Terms of Reference

4.1 Commissioner of the Domestic Homicide Review

4.1.1 The chair of the Safer Somerset Partnership has commissioned this review, following notification of the death of Ms A. in the Taunton Deane area of the county.

4.1.2 All other responsibility relating to the review commissioners (Safer Somerset Partnership) namely any changes to these Terms of Reference and the preparation, agreement and implementation of an Action Plan to take forward the local recommendations in the overview report will be the collective responsibility of the Partnership.

4.1.3 The resources required for completing this review will be secured by the chair of the Safer Somerset Partnership.

4.2 Aims of Domestic Homicide Review Process

4.2.1 Establish what lessons are to be learned from the alleged domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

4.2.2 Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

4.2.3 To produce a report which:

- summarises concisely the relevant chronology of events including:
  - the actions of all the involved agencies;
  - the observations (and any actions) of relatives, friends and workplace colleagues relevant to the review
- analyses and comments on the appropriateness of actions taken;
- makes recommendations which, if implemented, will better safeguard people experiencing domestic abuse, irrespective of the nature of the domestic abuse they've experienced.

4.2.4 Apply these lessons to service responses including changes to policies, procedures, and awareness-raising as appropriate.

4.3 Timescale

4.3.1 Aim to complete a final overview report by 31st January 2015 acknowledging that drafting the report will be dependent, to some extent, on the completion of individual management reviews to the standard and timescale required by the independent chair.

4.3.2 The outline timetable for the review is as noted in DHR Panel notes of 5th August 2015.

4.4 Scope of the review

4.4.1 To review events up to the domestic abuse related homicide of Ms A on 30th September 2014, unless it becomes apparent to the independent chair that the timescale in relation to some aspect of the review should be extended.

4.4.2 Events should be reviewed a minimum of 5 years preceding the domestic homicide.

4.4.3 It is known that the perpetrator spent considerable time in the county of Kent. Therefore the Safer Somerset Partnership will make a request to the relevant

Community Safety Partnership in Kent, to co-operate with (and participate in) the review.

4.4.4 To seek to fully involve the family, friends, and workplace colleagues within the review process.

4.4.5 This will include seeking to ascertain the views of the perpetrator and the perpetrator's ex-girlfriend to better understand the context in which this homicide occurred to aid the panel in preventing events of this nature again.

4.4.6 Consider how (and if knowledge of) the non-physical types of domestic abuse are understood by the local community at large – including family, friends, employer and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control are also fully explored.

4.4.7 Determine if there were any equality and diversity issues that may have meant Ms A found accessing specialist support difficult.

4.5 Twenty-three agencies/multi-agency partnerships/departments were contacted about this review initially in the Somerset area.

4.6 Fourteen agencies/partnerships confirmed that they had not had any relevant contact with either Ms A or Mr B . They were:

- BCHA (Somerset Changes and Integrated Domestic Abuse Services)- this organisation provided the specialist domestic abuse support services across Somerset County until January 2015. Since this time the commissioned provider has been Knightstone.
- Probation (National Probation Service and BGSW Community Rehabilitation Company)
- Mendip District Council
- Sedgemoor District Council
- West Somerset District Council
- Victim Support
- Turning Point (Somerset Drugs and Alcohol Service)
- Yeovil Hospital NHS Foundation Trust
- Local Safeguarding Children Board
- MARAC (Multi Agency Risk Assessment Conference)
- Somerset County Council Education/Vulnerable Learners
- Avon and Somerset Constabulary
- SARSAS (Somerset and Avon Rape and Sexual Abuse Support)
- Knightstone (Somerset Integrated Domestic Abuse Service)

4.7 The Kent Community Safety Partnership were also contacted as part of this review by the Independent Chair on 21st July 2015. This Community Safety Partnership contacted a range of agencies and only one agency had any relevant information and this was Canterbury and Coastal Clinical Commissioning Group. An IMR was commissioned to be

undertaken by this agency for the contact Mr B had had with the GP practice between December 2010 and February 2013.

4.8 Three agencies have assisted this review by bringing expertise in relation to drug and alcohol misuse (Turning Point), sexual violence and abuse (SARSAS) and domestic abuse (Somerset Integrated Domestic Abuse Service).

4.9 The following seven agencies submitted details of their involvement with either party on during late October early November 2014:

4.9.1 **South Somerset District Council** is one of five local authorities serving the county of Somerset. Their housing them confirmed that Mr B did register on Homefinder, which is the countywide housing need register in July 2014 which 'went live' in September 2014. There was no mention of Ms A in his application.

4.9.2 **Taunton Deane Borough Council** housing team confirmed that Ms A had a tenancy with Taunton Deane for the property in which she lived since 2002. There had been various contacts since this time, largely these were to report overgrown hedges, noise from dog barking or loud music. None of this was deemed, by the Panel, to be relevant to this review.

4.9.3 **Somerset Clinical Commissioning Group** confirmed that Ms A had been registered with a GP in the area since 2002. There had not been any disclosure of abuse and no attendance since January/February 2014 when she was treated for an underactive Thyroid problem. She also hadn't attended with any suggested symptoms where abuse may have been highlighted, for example anxiety or depression. The same agency had the following information recorded in Mr B's medical records. Mr B was diagnosed with a behaviour disorder in February 1999 when he was 11 years old and that he had an unpredictable mood, poor concentration and was shoplifting and refusing to attend school.

4.9.4 **Somerset Partnership NHS Foundation Trust** did have some information relating to Mr B during the years 1999-2007. In September 1999 an assessment was undertaken by the Mental Health team who diagnosed Mr B with Oppositional Defiant Disorder and Attention Deficit Hyperactivity Disorder (ADHD). He was then prescribed Ritalin to deal with the symptoms and offered support by the community team. However most importantly he was discharged from the Mental Health Adult Services in 2010 because Mr B advised the service he had been feeling ok.

4.9.5 Somerset County Council **Children Social Care** have a responsibility under 'Working Together to Safeguard Children 2015' to coordinate a response for children in need or in need of protection. Children Social Care confirmed that there had been some contact between 1999-2002 when an initial assessment was undertaken for Mr B, 15 years old, in 2002. It is unknown what the outcome or trigger was for this

4.9.6 **Adults Social Care** supports adults of a working age and older people who have disabilities, mental health problems, a sensory loss or general frailty. Somerset

County Council's aim is to actively promote independence and choice. Adult Social Care did not have any records or contact relevant to either party other than that mentioned above from children services

4.9.7 **South Western Ambulance Service NHS Foundation Trust** is the organisation to provide emergency ambulance services across the geographical area in which Ms A lived. They confirmed that the contact they had had with either party was on 30th September reporting the death of Ms A.

4.9.8 **Taunton and Somerset NHS Foundation Trust** is the Acute Hospital provider in the Somerset area. They confirmed that Ms A had attended for four outpatient physiotherapy sessions between 2011 and 2013. No abuse was disclosed and these appointments were not deemed to be relevant to any other history.

4.9.9 A chronology was compiled for this review however there was very minimal contact and relevance to this review therefore the review group agreed to not include this as an appendix.

5. Effective Practice/Lessons to be learnt

5.1 The following agencies either who had contact with Ms A or Mr B, or the Panel members have identified effective practice or lessons to be learnt.

5.2 Canterbury and Coastal Clinical Commissioning Group on behalf of Estuary Medical Centre

5.2.1 Action was taken by the GP at each visit Mr B made to the Medical Centre. The GP sought to offer solutions to Mr B's issues. However an opportunity to refer Mr B for the full psychiatric assessment following the recommendation of the funding panel was missed. Currently, there is no evidence to be found to link ADHD to domestic abuse or risk to others. Additionally, from the GP consultations and the absence of a MARAC (Multi agency Risk Assessment Conference) referral, there was no cause to suspect domestic abuse. However, the practice should work towards accessing training to improve awareness of domestic abuse and the potential impact of the combination of alcohol abuse, misuse of drugs and the mental ill health.

5.3 Somerset County Council

5.3.1 There was very little contact between this agency and either Ms A or Mr B. Their main contact was when Mr B was a child and there were issues raised with his behaviour. Somerset County Council do not have a stand alone domestic abuse policy however domestic abuse is regarded as a safeguarding issue and this is reiterated in training and documentation found online and accessible by all staff. This agency's working practice guidelines lack emphasis on coercive control and does not use the most current Home Office definition for domestic abuse unlike other statutory agencies.

5.4 Knightstone Housing (SIDAS)

5.4.1 This agency was invited to be part of the DHR by bringing their expertise of providing domestic abuse specialist support services. They do have a domestic abuse policy with a strong emphasis on safeguarding and thinking family. However the definition of domestic abuse used in this policy is not the most current Home Office version. The policy also does not cover employees working for this organisation who might be suffering from abuse.

5.5 Somerset and Avon Rape and Sexual Abuse Support (SARSAS)

5.5.1 This agency was invited to be part of the DHR by bringing their expertise of sexual violence. They did not have any contact with either party. Their safeguarding policy is not up to date with current legislation and domestic abuse is not specifically mentioned in any detail, particularly in relation to employees working for this organisation who may be suffering abuse.

5.6 Somerset Partnership NHS Foundation Trust

5.6.1 Once again, there had been very little contact between this agency and either party. Their domestic abuse policy is relatively clear and does recognise the employer's responsibility to employees who may be suffering abuse. However, one flowchart which describes the victim's pathway following disclosure was a little confusing and did not reflect the victim's consent, assuming that all victims, who disclose abuse, and their information will be shared with several agencies regardless of risk. This flowchart has now been amended and therefore improved to empower victims to choose whether they would like their information to be shared or not- subject to the level of risk they have been assessed at facing.

5.7 Avon and Somerset Constabulary

5.7.1 The review has highlighted that this agency had not had any contact with either party prior to the incidents of 30th September. The policies and procedures they have in place to respond and deal with domestic abuse are very comprehensive. It is understood that there is a stand alone policy for Clare's Law which sits outside of the domestic abuse policy.

5.8 Somerset Clinical Commissioning Group

5.8.1 No policy was submitted for this purpose.

5.9 There is effective practice in Somerset where agencies pull together and coordinate campaigns making it clear that domestic abuse is not the victim's fault. However, many posters and other materials do signpost towards a website for more information. Campaigns should not become too reliant on the internet because some households, like Ms A, did not have access to the internet.

5.10 All of the agencies should be encouraged to review their responses to domestic abuse in light of the new offence of controlling and coercive control under Serious Crime Act 2015.

6. Conclusions

6.1 In reaching their conclusions the Review Panel have focussed on the following questions;

- Has the DHR Panel fulfilled the Terms of Reference for this review by undertaking a variety of lines of enquiry, including reviewing contacts agencies had had with either party?
- Will the actions and suggestions for improvement improve the response domestic abuse victims have in the future?
- Was Ms A's death predictable?
- Could Ms A's death have been preventable?

6.2 The Review Panel are satisfied that the Terms of Reference have been fulfilled and that various lines of enquiry have been explored to ensure that as much information about either party was known prior to the tragic incidents on 30th September 2014.

6.3 The Panel is of the opinion that the agreed recommendations appropriately address the points raised throughout the review, particularly in relation to the lessons learnt.

6.4 Was Ms A's death predictable?

6.4.1 Mr B had previously as a child had some assessments by mental health practitioners. The outcome of these assessments diagnosed him with ADHD and prescribed medication for this from a young age. Mr B regularly used drugs (cocaine and MDMA) and alcohol from a young age, to which common side effects are known as mental stimulation, emotional warmth, general sense of wellbeing and decreased anxiety. Despite these known side effects his ex-partner advised the Panel that his behaviour did not change when under the influence of either drugs, alcohol or both. Mr B's mental health was assessed during this criminal investigation by two independent psychiatrists both of whom concluded that Mr B did not suffer with a mental illness or disorder.
In addition to this, neither party had ever come to the attention of any agency prior to the tragic incident of any signs of abuse being perpetrated or suffered.

6.4.2 The Review Panel therefore concludes that this death was not predictable given the information available to all of the agencies.

6.5 Could Ms A's death have been prevented?

6.5.1 The Review Panel conclude that there were no signs or a pattern of domestic abuse either being perpetrated by him or suffered by her in the lead up to her death in September 2014. There also was no evidence that there was a hostile relationship between them as mother and son. Mr B's demeanour was also thought not to change when he used drugs.

7. Recommendations

7.1 Canterbury and Coastal Clinical Commissioning Group on behalf of Estuary Medical Centre

7.1.1 The practice should access training to improve awareness of domestic abuse and the potential impact of the combination of alcohol abuse, misuse of drugs and the mental ill health. Two suggested e-learning packages can be accessed on the AVA website www.avaproject.org.uk

7.1.2 The practice should host an educational practice event so that colleagues of the medical centre can review the lessons learnt of this review when published, in particular that more informed consideration could be given to patients when they present with depression or anxiety.

7.2 DHR Panel members- Policies

7.2.1 To adopt the same definition of domestic abuse in their policies, namely the Home Office definition

7.2.2 To give due consideration, in their policies, to the issue of any member of the workforce perpetrating or suffering domestic abuse

7.2.3 To reference domestic abuse as a safeguarding issue using the reference the Adoption and Children Act 2002

7.2.4 To reference the new offence Coercive Control under the Serious Crime Act 2015 and consider what this means to their organisation.

7.3 Safer Somerset Partnership

7.3.1 To consider and develop a Communications Strategy about domestic abuse which can be coordinated and undertaken by the partnership in consultation with the local safeguarding adult and children boards and public health colleagues. The strategy should take into account various means of communication apart from the internet and this is with the aim of making the dynamics of domestic abuse clear to the community at large.

7.4 Somerset Drug and Alcohol Service

7.4.1 To keep abreast of research being undertaken in relation to the misuse of NPS substances with a view to sharing this learning across the partnership to prevent harm.

Somerset DHR Case 010 Action Plan

	Recommendation	Scope of recommendation ie. Local/ regional/ national	Action to take	Lead agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and outcome
1	The practice should access training to improve awareness of domestic abuse and the potential impact of the combination of alcohol abuse, misuse of drugs and the mental ill health.	Local	The practice to consider the e-learning packages available on the AVA website www.avaproject.org.uk which have been recognised as best practice.	Canterbury and Coastal Clinical Commissioning Group	Identify lead to review AVA e-learning Identified lead to determine who should complete e-learning and when Identified lead to ensure e-learning has taken place	July 2016	
2	The practice should host an educational practice event so that colleagues of the medical centre can review the lessons learnt of this review when published, in particular what options the GP might have when patients present with depression or anxiety.	Local	The practice to organise and host said event 3 months after publication of the review	Canterbury and Coastal Clinical Commissioning Group		October 2016	
3	All agencies who have been part of the review and any others deemed to be relevant by the Safer Somerset	Local- cross-county	Review domestic abuse policies and procedures – taking	Safer Somerset Partnership	Policies reviewed Policies updated (if	July 2016	

	Recommendation	Scope of recommendation ie. Local/ regional/ national	Action to take	Lead agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and outcome
	Partnership, to review their policies and procedures in relation to domestic abuse and consider the following points: Adopt the same definition of domestic abuse in their policies across the partnership, namely the Home Office definition Give due consideration, in their policies, to the issue of any member of their workforce perpetrating or suffering domestic abuse To reference domestic abuse as a safeguarding issue using the reference from the Adoption and Children Act 2002 To reference the new offence Coercive Control under the Serious Crime Act 2015 and consider what this means to their organisation.		into account the recommended points Update domestic abuse policies/ procedures as required and implement		required) Policies implemented and audited		

	Recommendation	Scope of recommendation ie. Local/ regional/ national	Action to take	Lead agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and outcome
4	To consider and develop a Communications Strategy/Plan about domestic abuse which can be coordinated and undertaken by the partnership in consultation with the local safeguarding adult and children boards and public health colleagues.	Local- cross county	A small task and finish group to be set up of those working in the field of domestic abuse and communication leads. The strategy should take into account various means of communication not just the internet. The aim of the strategy and delivery is to make the dynamics of domestic abuse clear to the community at large.	Safer Somerset Partnership in consultation with the local safeguarding boards and Public Health	Group established Existing plans/ strategies reviewed – ensuring all communication methods explored New plan agreed that includes non-internet methods of communication	October 2016	
5	To keep abreast of research being undertaken in relation to the misuse of NPS substances with a view to sharing this learning across the partnership to prevent harm.	Local	Somerset Drug and Alcohol Service			February 2017	