Public report

SAFER BARNSLEY PARTNERSHIP

BARNSLEY Metropolitan Borough Council

EXECUTIVE SUMMARY

Domestic Homicide Review

'Louise'

November 2015

Independent author
November 2016

Executive Summary

1 Introduction

This is an executive summary of a Domestic Homicide Review commissioned by the Safer Barnsley Partnership in relation to the murder of 'Louise' by her husband, on Saturday 7th November 2015, at their home address in Barnsley. Louise's husband then took his own life.

Comment: *Louise is a pseudonym chosen by the DHR panel. Louise's family did not feel able to contribute directly to the review, having dealt with the traumatic effects of her murder so recently. The panel respected the family's position and extended their sincere condolences to them for their sad loss.*

2 During the morning of 7th November 2015, the police were called to the couple's home address after friends had found Louise's husband in the house, apparently dead. The police then found Louise's body in another room.

3 Following a thorough police investigation, an inquest was held on 29th January 2016, which determined that Louise had been unlawfully killed and that Louise's husband had taken his own life. Summarising, the Coroner said, *"I think he knew what he was doing, I think he understood what the effect of what he was doing was, but I don't think he was thinking properly, if I can put it that way, but I think in law it still amounts to the fact that poor [Louise] was unlawfully killed*".

4 The police notified the Safer Barnsley Partnership (Community Safety Partnership) of the circumstances of Louise's death in November 2015. The case was subsequently discussed at a meeting of the newly established Domestic Homicide and Safeguarding Adults Review executive group on 14th January 2016, when the need to commission a DHR was recognised.

5 It soon became apparent that neither Louise nor Louise's husband had ever been involved with services in relation to domestic abuse. There had been minimal involvement with the police and with medical professionals, therefore the following agencies were asked to give chronological accounts of their contact with Louise and Louise's husband between 1st April 2015 and 7th November 2015. They were also asked to complete Individual Management Reviews (IMR's) detailing their involvement with the married couple.

6 Contributors to the review

- South Yorkshire Police
- Barnsley Clinical Commissioning Group
- Barnsley Hospital NHS Foundation Trust

7 The review panel members were:

Chair and author

Support to Chair

Barnsley Council

South Yorkshire Police

Barnsley Clinical Commissioning Group

Barnsley Hospital NHS Foundation Trust

8 The purpose of a DHR is to:

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

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

- Apply these lessons to service responses including changes to policies and procedures as appropriate

and

- Identify what needs to change to reduce the risk of such tragedies happening in the future and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working

- Ensure the review is conducted according to best practice, with effective analysis and conclusions of the information related to the case

- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence including their dependent children

- 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

- Apply these lessons to service responses including changes to policies and procedures as appropriate

- Reduce the risk of domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

- Whether family, friends or colleagues want to participate in the review and if so whether they were aware of any abusive behaviour from the alleged perpetrator to the victim, prior to the homicide.

9 The scope and terms of reference of the review

Scope

The review panel decided to examine each agency's involvement with Louise and her husband from 1st April 2015 to the date of their deaths on 7th November 2015. The review period was chosen because although there had been virtually no agency contact with the couple, the panel felt it appropriate and proportionate to the circumstances of the case to focus on the six-month period leading up to the dreadful events of 7th November 2015.

Terms of reference

The review addressed:

1. Whether the incident in which Louise died was a 'one off' or whether there were any warning signs and whether more could be done to raise awareness of services available to victims of domestic violence.

2. Whether there were any barriers experienced by Louise or family / friends / colleagues in reporting any abuse in Barnsley or elsewhere, including whether they knew how to report domestic abuse should they have wanted to.

3. Whether Louise had experienced abuse in previous relationships in Barnsley or elsewhere and whether this experience impacted on her likelihood of seeking support in the months before she died.

4. Whether there were opportunities for professionals to 'routinely enquire' as to any domestic abuse experienced by Louise that were missed.

5. Whether Louise's husband had any previous history of abusive behaviour to an intimate partner and whether this was known to any agencies.

6. Whether there were opportunities for agency intervention in relation to domestic abuse regarding Louise and her husband or to dependent children that were missed.

7. Whether any training or awareness raising requirements were identified to ensure a greater knowledge and understanding of domestic abuse processes and / or services in the Barnsley area.

8. Whether equality and diversity issues that appear pertinent to Louise, her husband, for example age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation were present.

10 The brief circumstances

Louise and Louise's husband married around 1992. They did not have any children together, but Louise had a daughter from a previous marriage. Louise's husband had been married before, but had no children of his own.

11 The couple had a loving relationship for many years. They were home owners and were financially stable. Louise's husband was retired and had a good income from pensions and investments. Louise worked and was also deeply involved in the care of her grandchildren. They were by all accounts a hardworking, loving and self-reliant couple.

12 During the summer and autumn of 2015, Louise's husband became increasingly concerned about financial investments he had made. The police had arrested his financial advisor and Louise's husband was worried about a transaction he had entered in relation to a rental property he owned. His concerns were unfounded, but nevertheless, they prayed heavily on his mind and eventually, he sought medical attention for it.

13 In the days leading up to the homicide, Louise's husband had also become fixated that his central heating system was faulty, despite an engineer telling him there was nothing wrong with it.

14 Louise gave up her job so that she could look after Louise's husband and take him to various medical appointments; she was extremely worried about him and the apparent decline in his mental health.

15 Engagement with family members

Louise's daughter elected not to be involved in the review at the moment. She is aware that should she change her mind, her participation would be welcomed. Similarly, Louise's brother had indicated that he could not cope with being involved in the process.

16 Louise's husband has only one known relative, an uncle who lives some distance away. He told the DHR report author that he had not seen Louise's husband or Louise for several years; he could not recall the last time they had spoken. He said Louise's husband was a quiet man who worked hard and got along with everyone; he always appeared to have a quiet and contented family life. The uncle added that to this day, he couldn't comprehend how such a gentle man could be capable of murdering his wife.

17 Information obtained by the police during their investigation was that Louise's husband doted on Louise and he had always been kind to Louise's daughter. Louise was described as a very positive, family orientated person who was always happy and optimistic. Louise's husband on the other hand was rather a pessimist.

18 Other background information

The only contact the police had with Louise was on 2nd November 2015, when she reported that Louise's husband may have signed-up with a fraudulent service on the internet. The police established that Louise's husband had not disclosed his bank details and their view was that he had nothing to worry about.

19 The police had contact with Louise's husband in 2011, when he reported the theft of solar lights from outside the family home and in 2012 and 2013, when he reported that horses were loose on a road.

20 On 19th October 2015, Louise's husband went to see his GP with Louise. He said he was feeling anxious, that he had financial problems and that he was unable to sleep. He was prescribed an antihistamine with a sedation effect to help with his anxiety and sleeping problems.

21 The last time Louise's husband and Louise went to the surgery was on 30th October 2015. A registered Mental Health Nurse saw him; Louise's husband told her he was becoming increasingly anxious which was affecting his mood, he was losing weight, he was not sleeping, his confidence and self-esteem were low and his concentration level was reduced.

22 The nurse diagnosed anxiety with depression and prescribed him anti-depressant medication and a follow-up appointment was made for 6th November 2015. The nurse also gave the couple information about anxiety and depression and asked Louise's husband if he would maintain a 'mood diary'.

23 Key issues arising from the review

The couple had little contact with any agency; what contact there was did not suggest for a minute that domestic abuse may have been a feature of their lives. It is therefore difficult to draw any lessons from this review.

24 The review identified the importance of well-documented, comprehensive and robust consultations, which includes both subjective and objective assessments.

25 Conclusions

- Louise's murder could not have been predicted or prevented.

- Louise and Louise's husband were in a loving and mutually supportive relationship for many years. There were no indications to any agency or third party of domestic abuse. It is likely that a sudden deterioration in Louise's husband's mental health led to him murdering Louise and then taking his own life.

- The panel considered whether the recognised side effects of the medication taken by Louise's husband (Sertraline) could have had a causative effect. Given that he was not seen by a medical professional after he had started taking the medication, there was no information available to the panel to enable it to reach a conclusion. The patient information leaflet for Sertraline warns of an increased risk of thoughts of self-harm and suicide, particularly in the first two-weeks of taking the medication. The available research presents a mixed picture, but the most recent systematic review / meta-analysis concluded that for adults there was no increased risk.

26 Recommendations

The only recommendations to come out of the review relate to the Clinical Commissioning Group and are as follows:

- General Practitioners in Barnsley should be reminded of the National Institute for Clinical Excellence [NICE] guidance on anxiety disorders with specific reference to the use of assessment tools.

- The CCG should ensure that staff working in primary care services understand the current referral criteria for the mental health Single Point of Access Service [SPA] provided by South West Yorkshire Partnership Foundation Trust