DOMESTIC HOMICIDE REVIEW

Basildon

Case of Anne

Althea Cribb

January 2016

NOTE

In most Domestic Homicide Reviews, alternative names are used to ensure the anonymity of the individuals. The individuals in this case are of Nigerian descent. Non-Nigerian names have been used in this report for the following reasons:

- There are different ethnicities within Nigeria and it could be offensive or distressing to choose a name from one that is not the same as the family.
- An alternative Nigerian name could belong to a member of the family, which could lead to distress.
- As the family declined to be involved they could not be consulted on appropriate alternative names.

1. Executive Summary

1.1 Outline of the incident

1.1.1 On the date of the homicide in 2013 Anne was found in her home having been stabbed. In April 2014 her son David was found guilty of manslaughter on the grounds of diminished responsibility.

1.1.2 He was sentenced in June 2015 to a Hybrid Order under section 45A of the Mental Health Act 1983 with a life imprisonment sentence term of 15 years three months. The Hybrid Order means that he will remain in hospital until it is deemed that he no longer requires further treatment, at which point he will be sent to a prison where he will serve the remainder of his sentence.

1.2 Domestic Homicide Reviews

1.2.1 Domestic Homicide Reviews (DHRs) were established under Section 9(3), Domestic Violence, Crime and Victims Act 2004 and are conducted in accordance with Home Office guidance.

1.2.2 The purpose of these reviews is to:

(a) 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.

(b) 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.

(c) Apply those lessons to service responses including changes to policies and procedures as appropriate.

(d) Prevent domestic homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

1.2.3 This review process does not take the place of the criminal or coroners courts nor does it take the form of a disciplinary process.

1.3 Terms of Reference

1.3.1 The full terms of reference are included at Appendix 1. The essence of this review is to establish how well the agencies worked both independently and together and to examine what lessons can be learnt for the future.

1.4 Independence

1.4.1 The Chair of the Review was Althea Cribb, an associate DHR Chair with Standing Together Against Domestic Violence. Althea has received training from

the then Chief Executive of Standing Together, Anthony Wills. Althea has over eight years experience working in the domestic violence and abuse sector, currently as a consultant supporting local strategic partnerships on their strategy and response to domestic violence and abuse. Althea has no connection with the Basildon Community Safety Partnership or any of the agencies involved in this case.

1.5 Parallel Reviews

1.5.1 There were no reviews conducted contemporaneously that impacted upon this review.

1.6 Methodology

1.6.1 The approach adopted was to seek Individual Management Reviews (IMRs) for all organisations and agencies that had contact with Anne and/or David. It was also considered helpful to involve those agencies that could have had a bearing on the circumstances of this case, even if they had not been previously aware of the individuals involved.

1.6.2 IMRs were received from:

(a) General Practitioners for Anne and David

(b) Victim Support Essex

(c) Basildon Borough Council

(d) Essex Police

(e) Colchester Hospital University Foundation NHS Trust (CHUFT)

(f) Basildon and Thurrock University Hospitals NHS Foundation Trust (BTUH)

(g) University of Essex

(h) David's secondary school[1]

1.6.3 Agency members not directly involved with the victim, perpetrator or any family members, undertook the IMRs.

1.6.4 The Review Panel members and Chair were:

(a) Althea Cribb, Chair, Standing Together Against Domestic Violence

(b) Dr Anoushka Luthra, Basildon and Brentwood Clinical Commissioning Group

(c) David Padgett, Victim Support Essex

[1] To protect the confidentiality of the family, all references to the school are anonymised.

(d) Paula Mason, Basildon Borough Council Community Safety

(e) DCI Tom Simons, Essex Police

(f) Representative, David's Secondary School

(g) Helen Edwardson, Colchester Hospital University NHS Foundation Trust

(h) Sarah Pope, Basildon and Thurrock University Hospitals NHS Foundation Trust

(i) Angela Jones, University of Essex

(j) Louise Mozzanica, National Probation Service

1.6.5 The Chair wishes to thank everyone who contributed their time, patience and cooperation to this review.

1.7 Contact with the family

1.7.1 The independent Chair made contact with family members of Anne and David through the Police Family Liaison Officer. This route was chosen due to the close and trusting relationship the Family Liaison Officer had developed with the family. The Family Liaison Officer had two separate conversations with the family and passed on letters from the independent Chair.

1.7.2 The response from the family, and friends, was that they did not want to be involved in the review; they reported through the Family Liaison Officer that they strongly felt that nothing could have been done to prevent the homicide. Given the sparse information provided within this review from agencies, the Panel discussed further options including going back to the family and friends to ask again, or contacting the church the family attended. Given the extended length of time since the homicide occurred, and the very strong feelings of the family, the Panel agreed that pursuing these contacts further could cause the family more distress and therefore no further contact was attempted.

1.7.3 The independent Chair also attempted contact with David via the hospital in which he is detained. David's doctor felt that it was not appropriate to discuss the Review with David and therefore he is not involved in the review.

1.7.4 A further contact was made towards the end of the review, to check the views of David's doctor again: he confirmed that David continued to not be in a position to discuss participation in the review.

1.8 Summary of the case

1.8.1 Anne was 44 years old at the time of her death, and worked as an accountant. She had two children; David was the older. During the Review Terms of Reference timeframe she had contact with:

(a) Her General Practitioner with regard to raised blood pressure from February 2010 to shortly before her death. At her last appointment Anne mentioned feeling tired and there was discussion as to whether she was entering early menopause.

(b) Basildon Council with regard to Council Tax, including arrears, from June 2004 to April 2013. She was provided with the number for Debtline in case she needed support; the Review was unable to establish whether she contacted them.

(c) Essex Police following an incident in which she was caught speeding (April 2010) and following a theft from a property she owned (June 2010). She was referred to Victim Support following the second incident, but they were unable to make contact.

(d) Basildon Hospital: in the Cardiac Clinic in June 2008, as a follow up for an Emergency Department attendance for chest pain in March 2008. She also attended for gynaecological issues from February 2010 to April 2011.

1.8.2 None of these contacts suggested any concerns with regards to Anne's home life or her relationship with David, or gave rise to concerns that would have triggered questioning on these matters.

1.8.3 The Chair felt that the GP could have enquired more with Anne about her personal circumstances following her disclosure in August 2013 that she was feeling tired (and may have done this, but not documented it); the notes of the discussion centred on whether she was entering early menopause. The CCG representative on the Panel felt that the GP's response was adequate.

1.8.4 No records could be reviewed by the Hospital with regard to Anne's attendance in 2008 for chest pains, as the systems have changed since then and the records are no longer available.

1.8.5 David was aged 21 at the time of the homicide. He had withdrawn from his university course in May 2013, and although he mentioned to the University that he had a job, the Review was unable to ascertain what this was. During the Review Terms of Reference timeframe he had contact with:

(a) His General Practitioner, firstly when they were notified that he had been diagnosed with hearing difficulties and was fitted with hearing aids (when he was a child); and later when he had a discussion about a career in medicine (January 2012), and received a prescription for a nasal spray (January 2013).

(b) Basildon Hospital to have hearing aids fitted in January 2010.

(c) The secondary school he attended from 2003 to 2010, where he performed well but was noted not to wear his prescribed hearing aid.

(d) University of Essex where he was a student for nearly three years until May 2013.

(e) Colchester Hospital for a soft tissue injury in his knee in May 2012.

(f) Essex Police when he was stopped and searched in March 2013.

1.8.6 None of these contacts suggested any concerns with regards to David's home life or his relationship with Anne, or gave rise to concerns that would have triggered questioning on these matters, or in relation to his mental health.

1.8.7 This is with the exception of the school, who were clear that they would respond more proactively to a situation in which a child was not wearing a prescribed hearing aid. It is possible that this could have led to more support for David around why he was not wearing his hearing aid: the notes suggest it was due to the family's religious beliefs but the full reasons are not known.

1.9 Issues raised in the Review

1.9.1 Given the information presented within this review, it is not possible to state that Anne's homicide could have been prevented. No agency had any indication, or concerns, that could have led to actions that may have prevented the incident.

1.9.2 In addition, the feedback from the family, when approached to be part of the review, was that they strongly felt that nothing could have been done to prevent the tragic event and as a result declined to be part of the review.

1.9.3 It is unusual in a Domestic Homicide Review to have both very little agency contact, and for that contact – as here – to indicate no significant concerns. Even in hindsight, with the benefit of bringing the chronology and IMR information together, the Panel could not identify any opportunities for this homicide to be prevented.

1.9.4 There were two instances in which Anne or David could have been supported differently:

(a) The school recognises that action should have been taken in response to David not wearing his hearing aid. The school confirmed to the review that they are confident this issue would now appropriately be responded to.

(b) It could be suggested that the GP could have probed Anne's social situation more when she reported feeling tired in August 2013. It is noted that this may have been done but not documented, and there is evidence of social enquiry in other appointments.

1.9.5 The information provided by David's school suggest some potential issues in the relationship between Anne and David. For example Anne appeared to not allow David to where a hearing aid and he was subsequently fitted for one once he was due to leave home. There was however nothing to suggest anything of

significant concern, and certainly nothing that would indicate the final tragic event.

1.9.6 While it could be suggested that more enquiry with David about the hearing aid issue by the school could have led to support for him in relation to his relationship with Anne, it would be a leap to suggest this could have changed the final outcome.

1.10 Recommendation

Recommendations identified in individual IMRs should be acted upon, and initial reports on progress should be made to the Basildon Community Safety Partnership within six months of the Review being approved by the Partnership.

2. DHR Basildon, Anne

Overview Report

Introduction

2.1 Outline of the incident

2.1.1 On the date of the homicide in 2013 Anne was found in her home having been stabbed. In April 2014 her son David was found guilty of manslaughter on the grounds of diminished responsibility.

2.1.2 He was sentenced in June 2015 to a Hybrid Order under section 45A of the Mental Health Act 1983 with a life imprisonment sentence term of 15 years three months. The Hybrid Order means that he will remain in hospital until it is deemed that he no longer requires further treatment, at which point he will be sent to a prison where he will serve the remainder of his sentence.

2.1.3 The sentence handed to David is the outcome of a situation in which multiple psychological assessments with David failed to agree on a diagnosis, and the jury in the trial had to decide between conflicting assessments: one judging him not to have a mental disorder that allowed for a verdict of diminished responsibility, and another (that they favoured) that did allow for that verdict.

2.2 Domestic Homicide Reviews

2.2.1 Domestic Homicide Reviews (DHRs) were established under Section 9(3), Domestic Violence, Crime and Victims Act 2004 and are conducted in accordance with Home Office guidance.

2.2.2 The purpose of these reviews is to:

(a) 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.

(b) 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.

(c) Apply those lessons to service responses including changes to policies and procedures as appropriate.

(d) Prevent domestic homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

2.2.3 This review process does not take the place of the criminal or coroners courts nor does it take the form of a disciplinary process.

2.3 Terms of Reference

2.3.1 The full terms of reference are included at Appendix 1. The essence of this review is to establish how well the agencies worked both independently and together and to examine what lessons can be learnt for the future.

2.3.2 The first meeting of the Review Panel was held on 9 June 2015. The Review Panel were asked to review events from 1 January 2003 up to the homicide. Agencies were asked to summarise any contact they had had with Anne or David prior to 1 January 2003.

2.3.3 Home Office guidance states that the Review should be completed within six months of the initial decision to establish one. This Review did not commence until almost two years after the homicide. This delay was due to discussions between Basildon Community Safety Partnership and the Home Office on whether the Review needed to proceed. Once the Review started in June 2015, it was ready within six months to be presented to the Community Safety Partnership.

2.4 Independence

2.4.1 The Chair of the Review was Althea Cribb, an associate DHR Chair with Standing Together Against Domestic Violence. Althea has received training from the then Chief Executive of Standing Together, Anthony Wills. Althea has over eight years experience working in the domestic violence and abuse sector, currently as a consultant supporting local strategic partnerships on their strategy and response to domestic violence and abuse. Althea has no connection with the Basildon Community Safety Partnership or any of the agencies involved in this case.

2.5 Parallel Reviews

2.5.1 There were no reviews conducted contemporaneously that impacted upon this review.

2.6 Methodology

2.6.1 The approach adopted was to seek Individual Management Reviews (IMRs) for all organisations and agencies that had contact with Anne and/or David. It was also considered helpful to involve those agencies that could have had a bearing on the circumstances of this case, even if they had not been previously aware of the individuals involved.

2.6.2 South Essex NHS Partnership Trust (mental health), Basildon Women's Aid, Essex Probation (now National Probation Service), and Basildon Borough

Council's Adults' and Children's Services reviewed their files and notified the DHR Review Panel that they had no involvement with Anne or David and therefore had no information for an IMR.

2.6.3 All IMRs included chronologies of each agency's contacts with the victim and/or perpetrator. On the whole, the IMRs provided were comprehensive and the analysis supported the findings. IMRs were received from:

(a) General Practitioners for the victim and perpetrator

(b) Victim Support Essex

(c) Basildon Borough Council

(d) Essex Police

(e) Colchester Hospital University Foundation NHS Trust (CHUFT)

(f) Basildon and Thurrock University Hospitals NHS Foundation Trust (BTUH)

(g) University of Essex

(h) David's secondary school

2.6.4 Agency members not directly involved with the victim, perpetrator or any family members, undertook the IMRs.

2.6.5 The Review Panel members and Chair were:

(a) Althea Cribb, Chair, Standing Together Against Domestic Violence

(b) Dr Anoushka Luthra, Basildon and Brentwood Clinical Commissioning Group

(c) David Padgett, Victim Support Essex

(d) Paula Mason, Basildon Borough Council Community Safety

(e) DCI Tom Simons, Essex Police

(f) Representative, David's Secondary School

(g) Helen Edwardson, Colchester Hospital University NHS Foundation Trust

(h) Sarah Pope, Basildon and Thurrock University Hospitals NHS Foundation Trust

(i) Angela Jones, University of Essex

2.6.6 The Chair wishes to thank everyone who contributed their time, patience and cooperation to this review.

2.7 Contact with the family

2.7.1 The independent Chair made contact with family members of Anne and David through the Police Family Liaison Officer. This decision was made due to the close and trusting relationship the Family Liaison Officer had developed with the family. The Family Liaison Officer had two separate conversations with the family and passed on letters from the independent Chair.

2.7.2 The response from the family, and friends, was that they did not want to be involved in the review; they reported through the Family Liaison Officer that they strongly felt that nothing could have been done to prevent the homicide. Given the sparse information provided within this review from agencies, the Panel discussed further options including going back to the family and friends to ask again, or contacting the church the family attended. Given the extended length of time since the homicide occurred, and the very strong feelings of the family, the Panel agreed that pursuing these contacts further could cause the family more distress and therefore no further contact was attempted.

2.7.3 The independent Chair also attempted contact with David via the hospital in which he is detained. David's doctor felt that it was not appropriate to discuss the Review with David and therefore he is not involved in the review.

2.7.4 A further contact was made towards the end of the review, to check the views of David's doctor again: he confirmed that David continued to not be in a position to participate in the review.

3. The Facts

3.1 Outline

3.1.1 On the date of the homicide in 2013, Anne was found in her home having been stabbed. In April 2014 her son David was found guilty of manslaughter on the grounds of diminished responsibility.

3.2 Information relating to Anne

3.2.1 Anne was 44 years old at the time of her death. She had two children; David was the older. Anne worked as an accountant.

3.3 Essex Police

3.3.1 Essex Police stopped Anne for speeding in April 2010 and issued her with a fixed penalty notice.

3.3.2 Anne's only other contact with Essex Police involved a theft from a property she owned and rented out. The incident took place in June 2010. The offender(s) was not traced and the crime remains undetected.

3.4 Victim Support

3.4.1 Victim Support received a referral from Essex Police as per the automated system following the incident of theft in June 2010.

3.4.2 Contact was attempted by telephone and Anne could not be reached. A letter was then sent offering support, and the case was then closed, pending contact from Anne (i.e. the case would have been reopened if she had made contact).

3.5 Basildon Borough Council

3.5.1 Anne's contact with the Council was with the Revenues and Benefits Department, with regard to Council Tax. This began when Anne registered as a resident of Basildon Borough and began to pay Council Tax in 2003.

3.5.2 Throughout the Terms of Reference timeframe, members of the Department had frequent contact with Anne due to outstanding payments she needed to make on her Council Tax. This continued up to the time of Anne's homicide.

3.5.3 Anne was provided with the number for Debtline in case she needed support. The Review was unable to establish whether she contacted them.

3.6 Basildon and Brentwood Clinical Commissioning Group – Anne's General Practitioner (GP)

3.6.1 Anne attended her GP regularly from February 2010 until shortly before her death with regards to high blood pressure.

3.6.2 At these appointments only her blood pressure results and medication were discussed. She attended 19 appointments in three and a half years – an average of once every two months, which given her raised blood pressure and need for reviews of medication, represented normal attendance.

3.6.3 The only exception to the above is her last appointment on 19 August 2013 at which the GP recorded that Anne complained of tiredness, although her appetite and weight were stable, and the discussion centred on whether she was entering early menopause.

3.7 Basildon and Thurrock University Hospitals NHS Foundation Trust (BTUH)

3.7.1 Anne attended the cardiac clinic in the hospital on 20 June 2008, as a follow up to an Emergency Department attendance on 11 March 2008 with chest pain. No records could be reviewed by the Hospital with regard to either of these attendances, as the systems have changed since then and the records are no longer available.

3.8 Information from the Family

3.8.1 No information was received from the family (please see paragraph 2.7 above for details of what attempts were made).

3.9 Information relating to David

3.9.1 David was aged 21 at the time of the homicide. He had withdrawn from his university course in May 2013, and although he mentioned to the University that he had a job, the Review was unable to ascertain what this was.

3.10 Essex Police

3.10.1 In March 2013 David was stopped by Police Officers in an area of Colchester where a number of burglaries had taken place. He was searched for stolen and prohibited articles; none were found.

3.11 Basildon and Brentwood Clinical Commissioning Group – David's General Practitioner (GP)

3.11.1 David was diagnosed with a hearing difficulty in September 2000 when he was eight years old. He was fitted for hearing aids shortly after this. The GP noted this in records having received the information from the Ear Nose and Throat Department of the family's local hospital at the time (not in Essex).

3.11.2 A letter from the Ear Nose and Throat Department was sent to David's GP on 2 April 2002 in which it was noted that he had "lost confidence to respond to threshold sounds accurately". There are no further notes relating to this and no further appointments.

3.11.3 In November 2010 David was transferred to the University of Essex General Practice.

3.11.4 In January 2012 David saw the GP “to discuss a career in medicine”.

3.11.5 David saw the GP in January 2013 for a repeat prescription of his nasal spray. It was noted that he stated that his “compliance is poor” with the spray but that he was aware he needed to stop his symptoms before exams. A repeat prescription was provided.

3.12 Basildon and Thurrock University Hospitals NHS Foundation Trust (BTUH)

3.12.1 David attended the Audiology Department for an appointment on 7 January 2010. He stated that he required hearing aids as he was going to University in the September. The hearing aids were fitted, and he did not need to return to the Department.

3.13 Colchester Hospital University Foundation NHS Trust (CHUFT)

3.13.1 David attended the Accident and Emergency Department of the Hospital on 29 May 2012 with a soft tissue injury in his knee. He was given painkillers and crutches to aid mobility.

3.13.2 David did not attend the follow up outpatient appointment and was discharged. This was recorded as an “open” appointment, which the patient is not required to attend if they feel they do not need further advice or treatment.

3.14 David’s School

3.14.1 David attended the school from 2003 to 2010. He was regularly commended for his attendance and academic achievements.

3.14.2 The information received by the school from David’s primary school was that he had “quite severe hearing problems. Parents do not really accept this, i.e. it is God’s will and he will cure. Has had hearing aid but no longer wears it. Strict Christian upbringing”. The IMR author indicates that there is no evidence he wore his hearing aid throughout his time at the school.

3.14.3 In March 2004 David received a letter from the Head Teacher congratulating him on 11 A’s for effort in his interim report. Anne’s reply slip states that David “needs to improve in most of the subjects”.

3.14.4 In March 2005 David received a letter from the Head Teacher congratulating him on 8 A’s for effort in his interim report. In December 2005 he received a letter from the Head of French informing David’s parents that he was the “best achiever” for the Autumn Term. Anne’s reply slip states that she is pleased with his results but that he needs to do better in science. She also comments that he

needs to work harder. She requested the name of textbooks that she can get so that David can work at home on them.

3.14.5 In January 2006 and 2007 David received further letters similar to those above, praising him for attendance and effort. In August of 2007 his application to be a prefect was successful.

3.14.6 David took his GCSE's in June 2008, and his A Levels in June 2010, after which he left the school.

3.15 University of Essex

3.15.1 David attended the University from October 2010 to May 2013 on a Biology degree course.

3.15.2 David contacted Student Support Services for information about financial support in October 2010, and was provided with information.

3.15.3 In November 2010 he enquired about exam arrangements on the grounds of religious observance, as he could not attend exams on a Saturday. The Service provided him with an application form and advised him to submit it with evidence. The application form was submitted shortly after, and the Service then requested evidence from David, for example from a Minister, that David was practicing. David explained that it would be difficult for him to obtain a letter from a local church, and asked whether a letter from his home church would be acceptable. This was confirmed, however David then responded, "his mother did not want him to approach his church for a letter". As evidence was not produced, his application was withdrawn.

3.15.4 David's next contact was in March 2013, in which he requested special exam arrangements due to "disability", the details of which were that he was aware of his own noisy breathing in exams and that this was a concern to others taking exams – and as a result he tried to hold his breath, which made him feel faint. He was advised to submit an "extenuating circumstances" form to alert examiners how this had impacted on his exam performance. The outcome of this is not recorded.

3.15.5 Shortly after, in April 2013, David informed Student Services that he had decided to withdraw and enquired about how this would impact on his fees. Advice was given.

3.15.6 In May 2013 David informed the Service that he had decided not to take the final exams. The Department had recommended to him that he "intermit" (take a break from studies) rather than withdraw, but David wanted to withdraw as he stated he had a job. He stated that he had missed work that year, as he had bad eczema in his hands and feet, causing issues with mobility, fatigue and concentration. The evidence for this was receipts for eczema medication. He also stated he had had problems with housemates; this was not expanded upon.

3.15.7 The Service advised David to apply for intermission, and that if this were unsuccessful to alert the board of examiners via extenuating circumstances as to why he hadn't sat his exams. He was advised to try not to withdraw, and was shown the online form for intermission, and the Adviser discussed what he would need to put on the form. David decided to withdraw.

3.15.8 David's tutor in the Biological Sciences Department stated after the homicide that David "had lots of time from his tutor, the director of education and the department administrator but we found him very guarded. … He was reluctant to provide supporting evidence [for deferring his exams]."

3.16 Information from David

3.16.1 No information was received from David (please see paragraph 2.7 above for details of what attempts were made).

4. Analysis

4.1 Domestic Abuse/Violence Definition

4.1.1 The government definition of domestic violence and abuse is:

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological; physical; sexual; financial; and emotional.

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

4.1.2 No information was presented within this review to suggest that Anne was a victim of domestic abuse from David.

4.1.3 Due to the nature of David's conviction, and psychological assessment, the Panel and IMR authors were also asked to identify any opportunity to identify mental health concerns with David. No mental health concerns were raised by any agency in contact with David.

4.2 Essex Police, Victim Support, Colchester Hospital University NHS Foundation Trust, Basildon and Thurrock University Hospitals NHS Foundation Trust

4.2.1 None of the chronologies and IMRs from these organisations presented any issues of concern either at the time of their contact with Anne or David, or in hindsight as a result of the Review.

4.3 General Practitioners

4.3.1 The only occasion when there was discussion with Anne that was not limited to her blood pressure management and medication was her last appointment on 19th August 2013. The GP recorded that Anne complained of tiredness, although her appetite and weight were stable, and the notes of the discussion centred on whether she was entering early menopause.

4.3.2 The Chair felt that the GP could have enquired more with Anne about her personal circumstances (and may have done this, but not documented it); the

notes of the discussion centred on whether she was entering early menopause. We now know that at this time David was living at home having left University early.

4.3.3 It is only in hindsight that this discussion appears to be an omission (and in fact it may have taken place, but not been recorded in the notes), The CCG representative on the Panel felt that the GP's response was adequate. Without a definitive mental health diagnosis, or any other evidence of any difficulties (e.g. from the family), it would be a leap to suggest that a more in depth discussion could have alerted the GP to any areas of concern.

4.4 University of Essex

4.4.1 Likewise, it would have been appropriate for staff at the University to have further questioned David in relation to his decision to leave University before completing his degree.

4.4.2 However, the University were acting only in response to David's statement that he had a job, and there were no other signs or triggers to indicate concern.

4.5 Basildon Borough Council

4.5.1 The IMR highlights that there was nothing in Anne's presentation to the council that indicated vulnerability, or other concern over and above the need to address her Council Tax payments.

4.5.2 In completing the IMR, it became apparent to the author that a policy and procedure was required for this Department to identify vulnerability prior to referral to bailiffs or debt recovery service and respond appropriately. It is noted that the presence of this policy at the time of Anne's contact with the Council would not have changed the nature of that contact as Anne was not identified as vulnerable at the time or as part of this review.

4.6 David's School

4.6.1 The IMR author expressed concern that the school did not act on the fact that David did not wear his hearing aid. Although it was noted that the absence of his hearing aid did not significantly impair his learning, it was felt that a safeguarding concern should have been raised, and that if a similar issue were presented in the school now, that a concern would be raised.

4.6.2 While it was noted that Anne often responded to news of David's achievements with statements that he must try harder, this would not raise concerns with the school.

4.7 Diversity

4.7.1 *Gender*

Being female is a risk factor for being a victim of domestic abuse/violence, making this characteristic relevant for this case had Anne been a victim of domestic abuse/violence, however no information was presented within the review to indicate that this was the case.

4.7.2 *Race*

While it was noted that Anne and David were Nigerian, no information was presented within the review to indicate any issues linked to this in relation to their contact with agencies.

4.7.3 *Religion and Belief*

Anne's and David's Christian faith was mentioned in the IMRs for David's school and the University of Essex. In particular, it was noted as the reason for David not wearing his hearing aid. The school have addressed the fact that this issue should have been followed up on and this would be done now.

4.7.4 *Age; disability; sexual orientation; gender reassignment; marriage / civil partnership; pregnancy and maternity*

No information was presented within the review to indicate these were issues.

5. Conclusions and Recommendations

5.1 Preventability

5.1.1 Given the information presented within this review, it is not possible to state that Anne's homicide could have been prevented. No agency had any indication, or concerns, that could have led to actions that may have prevented the incident.

5.1.2 In addition, the feedback from the family, when approached to be part of the review, was that they strongly felt that nothing could have been done to prevent the tragic event and as a result declined to be part of the review.

5.2 Issues raised by the review

5.2.1 It is unusual in a Domestic Homicide Review to have both very little agency contact, and for that contact – as here – to indicate no significant concerns. Even in hindsight, with the benefit of bringing the chronology and IMR information together, the Panel could not identify any opportunities for this homicide to be prevented.

5.2.2 There were two instances in which Anne or David could have been supported differently:

(a) The school recognises that action should have been taken in response to David not wearing his hearing aid. The school confirmed to the review that they are confident this issue would now appropriately be responded to.

(b) The Chair felt that GP could have probed Anne's social situation more when she reported feeling tired in August 2013 (they may have done so but not recorded it) This suggestion was not agreed with by the CCG epresentative. It would be a leap to suggest that a more in depth discussion could have alerted the GP to any areas of concern that would have changed the outcome.

5.2.3 The information provided by David's school suggest some potential issues in the relationship between Anne and David. For example Anne appeared to not allow David to wear a hearing aid and he was subsequently fitted for one once he was due to leave home. There was however nothing to suggest anything of significant concern, and certainly nothing that would indicate the final tragic event.

5.2.4 While it could be suggested that more enquiry with David about the hearing aid issue by the school could have led to support for him in relation to his relationship with Anne, it would be a significant leap to suggest this could have changed the final outcome.

5.3 Recommendation

Recommendations identified in individual IMRs should be acted upon, and initial reports on progress should be made to the Basildon Community Safety Partnership within six months of the Review being approved by the Partnership.

Appendix 1: Domestic Homicide Review Terms of Reference

This Domestic Homicide Review is being completed to consider agency involvement with Anne, and her son DK following her death on 26 September 2013. The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

Purpose

1. Domestic Homicide Reviews (DHR) place a statutory responsibility on organisations to share information. Information shared for the purpose of the DHR will remain confidential to the panel, until the panel agree what information should be shared in the final report when published.

2. To review the involvement of each individual agency, statutory and non-statutory, with Anne and David during the relevant period of time: 1 January 2003 to 26 September 2013.

3. To summarise agency involvement prior to 1 January 2003.

4. To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to identify and respond to disclosures of domestic abuse.

5. To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result and as a consequence.

6. To improve inter-agency working and better safeguard adults experiencing domestic abuse and not to seek to apportion blame to individuals or agencies.

7. A suitably experienced and independent person has been commissioned to:
   a) chair the Domestic Homicide Review Panel;
   b) co-ordinate the review process;
   c) quality assure the approach and challenge agencies where necessary; and
   d) produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established terms of reference.

8. To conduct the process as swiftly as possible, bearing in mind the significant delay between the homicide and starting the DHR (due to discussion between Basildon Community Safety Partnership and the Home Office on the establishing of the Review).

9. On completion present the full report to the Basildon Community Safety Partnership*.*

Membership

10. It is critical to the effectiveness of the meeting and the DHR that the correct management representatives attend the panel meetings. Agency representatives have knowledge of the matter, the influence to obtain material efficiently and the ability to comment on the analysis of evidence and recommendations that emerge.

11. The following agencies are to be involved:
    a) Basildon and Brentwood Clinical Commissioning Group
    b) Victim Support Essex
    c) Basildon Borough Council Community Safety
    d) Essex Police
    e) David's secondary school
    f) Colchester Hospital University NHS Foundation Trust
    g) Basildon and Thurrock University Hospitals NHS Foundation Trust
    h) University of Essex

12. The following agencies will submit a chronology and Individual Management Review (IMR):
    a) General Practitioners for the victim and perpetrator
    b) Victim Support Essex
    c) Basildon Borough Council
    d) Essex Police
    e) Colchester Hospital University NHS Foundation Trust
    f) Basildon and Thurrock University Hospitals NHS Foundation Trust
    g) University of Essex
    h) David's secondary school

13. South Essex NHS Partnership Trust will be contacted, and if they had involvement, will be requested to be part of the Review (and Terms of Reference amended accordingly).

14. The representative from the Clinical Commissioning Group, in addition to contributing to the Review as a substantive member, will also act as a specialist expert in relation to mental health.

Collating evidence

15. Each agency will search all their records outside the identified time period to ensure no relevant information is omitted, and secure all relevant records.

16. Each relevant agency will provide a chronology of their involvement with Anne and/or David during the relevant time period.

17. Each relevant agency will prepare an Individual Management Review (IMR), which:
    a) sets out the facts of their involvement with Anne and/or David;
    b) critically analyses the service they provided in line with the specific terms of reference;
    c) identifies any recommendations for practice or policy in relation to their agency, and
    d) considers issues of agency activity in other boroughs and reviews the impact in this specific case.

18. Agencies that have had no contact should attempt to develop an understanding of why this is the case and how procedures could be changed within the partnership which could have brought Anne or David in contact with their agency.

Analysis of findings

19. In order to critically analyse the incident and the agencies' responses to the family, this review will specifically consider the following points:
    a) Analyse the communication, procedures and discussions, which took place within and between agencies.
    b) Analyse the co-operation between different agencies involved with the victim, perpetrator, and wider family.
    c) Analyse the opportunity for agencies to identify and assess domestic abuse risk or mental health risk.
    d) Analyse agency responses to any identification of domestic abuse issues or mental health issues.
    e) Analyse organisations' access to specialist domestic abuse agencies or mental health specialist agencies.
    f) Analyse the training available to the agencies involved on domestic abuse issues or mental health issues.

Liaison with the family and the perpetrator

20. The Panel is aware that, with the homicide having occurred in August 2013, involvement of family and friends will need to be carefully managed.

21. We aim to sensitively involve the son, brother and boyfriend of the victim in the review, identifying the most appropriate method and route of contact bearing in mind the length of time since the homicide and the fact that they are also the family of the perpetrator.

22. We aim to sensitively involve the perpetrator (via the institution in which he is held), who may be able to add value to this process.

23. The chair will lead on family engagement with the support of relevant Panel members, including coordination of family liaison to reduce the emotional hurt caused to the family by being contacted by a number of agencies and having to repeat information.

Development of an action plan

24. Individual agencies will take responsibility to establish clear action plans for agency implementation as a consequence of any recommendations in their IMRs. The Overview Report will set out the requirements in relation to reporting on action plan progress to the Community Safety Partnership.

25. Community Safety Partnership to establish a multi-agency action plan as a consequence of the recommendations arising out of the Overview Report, for submission to the Home Office along with the Overview Report and Executive Summary.

Media handling

26. Any enquiries from the media and family should be forwarded to the chair who will liaise with the CSP. Panel members are asked not to comment if requested. The chair will make no comment apart from stating that a review is underway and will report in due course.

27. The CSP is responsible for the final publication of the report and for all feedback to staff, family members and the media.

Confidentiality

28. All information discussed is strictly confidential and must not be disclosed to third parties without the agreement of the responsible agency's representative. That is, no material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.

29. All agency representatives are personally responsible for the safe keeping of all documentation that they possess in relation to this DHR and for the secure retention and disposal of that information in a confidential manner.

30. It is recommended that all members of the Review Panel set up a secure email system, e.g. registering for criminal justice secure mail, nhs.net, gsi.gov.uk, pnn or GCSX. Confidential information must not be sent through any other email system. Documents will all be password protected.

Disclosure

31. Disclosure of facts or sensitive information may be a concern for some agencies. We manage the review safely and appropriately so that problems do not arise and by not delaying the review process we achieve outcomes in a timely fashion, which can help to safeguard others.

Appendix 2: Action Plan

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
Policy and Procedure to be developed to identify vulnerability prior to referral to bailiffs or debt recovery service and respond appropriately.	Local	Develop Revenues Vulnerability Policy	Basildon Borough Council	Enforcement Companies on the current contract for Council Tax collection which commenced on 1st June 2015 went through a lengthy procurement exercise, part of which was to ensure the Council's safeguarding requirements are adhered to, as well as producing their own workable vulnerability policies. Basildon Council Revenues Services has developed a working document to identify vulnerability at the earliest opportunity, offering early intervention and support.	December 2015	CSP Strategy Group at its meeting on 21 January 2016 noted the completion and implementation of the Policy.

Appendix 3: Home Office Quality Assurance Panel Response

Home Office

Public Protection Unit T: 020 7035 4848
2 Marsham Street www.gov.uk/homeoffice
London
SW1P 4DF

Paula Mason
Community Safety Manager
Basildon Borough Council
The Basildon Centre
St Martin's Square
Basildon
Essex SS14 1DL

4 May 2016

Dear Ms Mason,

Thank you for submitting the Domestic Homicide Review (DHR) report for Basildon to the Home Office Quality Assurance (QA) Panel. The report was considered at the Quality Assurance Panel meeting on 23 March 2016.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel concluded this was a good review but felt that it may be helpful if the report could draw from the trial notes on the circumstances that resulted in this sad homicide to help inform the review. The Panel noted that no learning has been extracted from the review and felt that the report may benefit from being considered by cultural and faith-based specialists given it alludes to cultural sensitivities.

There were other aspects of the report which the Panel felt could be revised, or benefit from further analysis, which you may wish to consider before you publish the final report:

- The Panel concluded that it may have be been useful to contact work colleagues and house mates to obtain alternative perspectives;

- Given the circumstances of the case, the report could have usefully addressed the stigma of disability in certain communities;

- The Panel felt that the potential impact of the family's interpretation of their faith could have been further probed;

- The Panel questioned the relevance of paragraphs 3.6.4 and 3.7.2.

The Panel does not need to see another version of the report, but I would be grateful if you could include our letter as an appendix to the report.

I would be grateful if you could email us at DHREnquiries@homeoffice.gsi.gov.uk and provide us with the URL to the report when it is published.

The QA Panel felt it would be helpful to routinely sight Police and Crime Commissioners on DHRs in their local area. I am, accordingly, copying this letter to the PCC for information.

Yours sincerely

Christian Papaleontiou
Chair of the Home Office DHR Quality Assurance Panel