Domestic Homicide Review (DHR)

Southend Community Safety Partnership

Overview Report into the death of

“Martine” January 2019

Author’s Name

Tracy Hawkings B. Ed

Overview Report author

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SUMMARY OF CONTENTS

PREFACE

This is a Domestic Homicide Review Report referring to the life and death of “Martine”. This is the pseudonym chosen by her family and will be used throughout this report.

I would like to begin by expressing my sincere sympathies, and that of the panel, to the family and friends of “Martine”. I am sorry for their loss and hope that in some way this report provides an insight into to her life and a voice to her story.

In paying tribute to Martine, her family have said "Like all families we had our ups and downs but even through the difficulties we loved her deeply. She was an independent and proud woman unwaveringly loyal and had a strong personality. She was very funny, making us smile when she laughed at her own jokes, even the bad ones. We are all absolutely heartbroken, and devasted by her death. You always think you have time to put things right – she mattered."

I would like to thank the panel and those that provided chronologies and individual management reviews for their time and co-operation.

1.0 INTRODUCTION

1.1. This is the report of a Domestic Homicide Review (DHR) commissioned by the Chair of Southend Community Safety Partnership (SCSP) under the centralised process agreed by the Southend, Essex and Thurrock Domestic Abuse Board (SETDAB). It examines agency responses and support given to Martine, a resident of Southend-on-Sea prior to her murder in January 2019.

1.2. The primary purpose of a Domestic Homicide Review (DHR) is to enable learning where a person has died as a result of domestic abuse. In order for the learning to be shared 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 tragedies happening again in the future.

1.3. This report will consider the contact that agencies had with Martine between April 2018 and the date of her murder in January 2019. These dates provide an overview of the period of time, Martine was in a relationship with Adult B, the person responsible for her murder.

1.4. In addition to agency involvement the review has also sought to examine the past to identify any relevant background or specific risks to Martine and whether there were opportunities to provide further support to her. The report considers whether there were any barriers to accessing services. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer. This report also summarises the circumstances which led to the review being undertaken in this case.

1.5. Every effort has been made to conduct this review process with an open mindset and to avoid hindsight bias. Those leading the review have sought the views of family members and made every attempt to manage the process with compassion and sensitivity.

2.0 TIMESCALES

2.1. Southend Community Safety Partnership commissioned this review on 21st February 2019. The review adhered to the processes detailed in the Home Office Statutory Guidance for the conduct of Domestic Homicide Reviews published in December 2016.

2.2. The decision to commission the review was taken by the DHR Core Group for SETDAB. The Home Office were informed of the review on 7th March 2019.

2.3. This review commenced on 28th May 2019. The Home Office Statutory Guidance advises that where practically possible the Domestic Homicide Review should be completed within six months of the decision to proceed with the review. For this reason, an initial timetable was drawn up to ensure that agencies complied with the request. The review was unable to be completed in the six-month time frame due to the on-going criminal proceedings which did not conclude until 12th July 2019. This caused a delay in the Independent Chair and Report Author making personal contact with the family of Martine to establish if they wanted to take part in the review. There was also a delay in receiving information from two of the professional agencies involved with this review and in identifying and commissioning the services of experts to advise the panel on the subject of drug dependency and prescription drugs.

2.4. The Independent Chair and Overview Report Author were formally appointed at the first panel meeting on 28th May 2019. During this initial meeting, the draft terms of reference were discussed and subsequently agreed on 29th August 2019.

2.5. The family of Martine were contacted after the criminal proceedings had concluded and invited to actively contribute to the review.

2.6. A letter was written by the review panel chair to the mother of Martine on 2nd June 2019 and delivered by the police family liaison officer. The letter provided information about the review and extended an invitation for the family to take part in it. The family have also had contact with an advocate from the Victim Support Service. The Report Author met with Martine's mother and younger sister in October 2019 and January 2020. Both meetings took place at the home of Martine's mother.

2.7. The panel met on four occasions and contact was made with panel members on a regular basis to clarify issues and matters of accuracy about their agency's involvement with the family.

2.8. The review concluded in May 2020. The Southend Community Safety Partnership were updated regarding the progress of the review throughout the process.

2.9. A draft Overview Report was completed, and the family were then contacted and provided with a copy to enable them to contribute further to its content. The family were happy with the content of the report.

2.10. The DHR report was sent to the Home Office to be quality assessed. As a result of this process, additional enquiries were made with two of the agencies involved and amendments made to the report. The amended report was provided to the family for their comment and a zoom meeting arranged with the Report Author who went through the report with them.

3.0 CONFIDENTIALITY

3.1. The findings of each review are confidential. The information obtained as part of the review has only been made available to participating professionals and their line managers. The family of Martine were provided with a copy of the report prior to submission to the Home Office and were also advised about confidentiality.

3.2. Before the report is published the Southend, Essex & Thurrock (SET) Domestic Abuse Team and Southend Community Safety Partnership will circulate the final version to all members of the review panel and the family members. The family will be notified of the publication date.

3.3. The content of the Overview Report has been anonymised to protect the identity of the victim, relevant family members and all others involved in this review. The pseudonyms agreed with the family/panel are as follows:

Martine – Female who was murdered. Aged 40 years old at the time of her death. Ethnicity – White British

Adult B – Male partner of Martine and person responsible. Aged 32 years. Ethnicity - White British.

Adult C – Mother of Martine

Adult D – Deceased ex-partner of Martine.

4.0 TERMS OF REFERENCE

Statutory Guidance (Section 2.7) states the purpose of the DHR Review is to:

4.1. Establish what lessons are to be learned from the domestic homicide involving Martine and Adult B regarding the way in which local professionals and organisations work individually and together to safeguard victims;

4.2. 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;

4.3. Apply these lessons to service responses including changes to policies and procedures as appropriate; and

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

4.5. Contribute to a better understanding of the nature of domestic violence and abuse and highlight good practice.

Specific terms of reference set for this review

4.6. To provide an Overview Report which articulates the life of the victim through her eyes to understand her reality in her dealings with those around her including professionals.

4.7. To identify the history of the victim and perpetrator and provide a detailed chronology of relevant agency contact with them. The time period to be examined in detail is the date the couple are believed to have started their relationship (April 2018) and the date of the victim's homicide in January 2019.

4.8. Agencies with knowledge of either the victim and/or perpetrator which falls outside of that timescale are to provide a brief summary of that involvement.

4.9. To examine whether there were signs or behaviours exhibited by either the victim or perpetrator in their contact with services which could have indicated the level of risk.

4.10. Agencies reporting involvement with the victim and/or the perpetrator to assess whether the services provided offered appropriate interventions, risk assessments, care plans and resources. Assessment should include analysis of any organisational and/or frontline practice level factors which impacted upon service delivery.

4.11. What learning if any is there to be identified in the management of either party. Is there any good or poor practice relating to this case that the Review should learn from. Each agency is asked to examine best practice in their specialist area and determine whether there are any changes to systems or ways of operating that can reduce the risk of a similar fatal incident taking place in future.

4.12. The following are key issues which will be explored further with the relevant agencies in the review:

- Martine's history of mental ill-health and dependency on drugs and alcohol.
- Adult B's history of alcohol and/or drugs dependency.
- Martine's history of domestic abuse with previous partners.
- Martine's attendance at Queensway Centre and Taylor Centre in the weeks prior to her homicide where concerns were raised connected to her relationship with Adult B.
- Martine's attendance at Southend General Hospital on 6th December 2018, following an overdose of prescribed drugs, alcohol and cocaine. Martine reported a contributing factor to be an altercation with her partner, Adult B.

5.0 METHODOLOGY

5.1. The method for conducting DHR's are prescribed by the Home Office Guidelines[1]. These guidelines state:

"Reviews should illuminate the past to make the future safer and it follows therefore that reviews should be professionally curious, find the trail of abuse and identify which agencies had contact with the victim, perpetrator or family and which agencies were in contact with each other. From this position, appropriate solutions can be recommended to help recognise abuse and either signpost victims to suitable support or design safer interventions".

[1] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews. Home Office 2016.

5.2. Following the decision to undertake the review, all agencies were asked to check their records about any interaction with Martine or Adult B.

5.3. Where it was established that there had been contact the SCSP ensured that all agencies promptly secured all relevant documents, and those who could make an appropriate contribution were invited to become panel members. Agencies that were deemed to have relevant contact were then asked to provide an Individual Management Review (IMR) and a chronology detailing the specific nature of that contact.

5.4. The aim of the IMR is to look openly and critically at individual and organisational practice to see whether the case indicates that changes could or should be made to agency policies and practice. Where changes were required then each IMR also identified how those changes would be implemented.

5.5. Each agency's IMR covered details of their interaction with Martine, and whether they had followed internal procedures. Where appropriate the report writers made recommendations relevant to their own agencies and prepared action plans to address them. Participating agencies were advised to ensure their actions were taken to address lessons learnt as early as possible. As part of this process IMR authors, where appropriate interviewed the relevant staff from their agencies. All GP's who treated Martine were interviewed by the GP's Head of Practice as part of the IMR process. In addition, the IMR author interviewed the GP who treated Martine on the last occasion she visited the surgery in January 2019.

5.6. The findings from the IMR reports were endorsed and quality assured by senior officers within the respective organisations who commissioned the report and who are responsible for ensuring that the recommendations within the IMRs are implemented.

5.7. On request from the independent chair, some authors provided additional information to clarify issues raised individually and collectively within the IMRs. Contact was made directly with those agencies outside of the formal panel meetings.

5.8. Those agencies who provided IMR's or reports are detailed within section seven of this report.

5.9. As part of the review, the panel engaged the services of an independent expert on drugs and alcohol dependency and an expert on medicines to act as advisers. The review author met with both experts

outside of the panel process to discuss the level of medication Martine was prescribed. The findings of the experts were reported during panel meetings and feature in this report.

6.0 INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES, NEIGHBOURS AND WIDER COMMUNITY

6.1. In June 2019, the DHR Chair wrote a number of letters to the family and two close friends of Martine. The DHR Chair also wrote to Adult B and his mother and sister. All parties were provided with a copy of the Home Office DHR leaflet entitled 'Domestic Homicide Review Information- Leaflet for Family Members'.

6.2. The family of Martine did have the opportunity to engage with an advocate from the Homicide Support Team within Victim Support and had an initial meeting with them following Martine's homicide. The advocate provided general support during the initial stages of the investigation. A second meeting was arranged but cancelled by the family and thereafter telephone support was made available to them. The family were also supported by a Police Family Liaison Officer (FLO) during the investigation and judicial proceedings.

6.3. The DHR Chair had two meetings with the mother and sister of Martine and spoke to her mother on the telephone on other occasions. Information provided by Martine's mother is incorporated into the background section of this report.

6.4. In December 2019, Adult B contacted the Independent Chair to confirm he was willing to take part in the review. A visit was arranged and took place on 30th January 2020. Information provided by Adult B is detailed within the chronology, section (14) of this report.

6.5. The DHR Panel were keen to find out more information about Adult B as very little information was known about him within records held by the statutory agencies. One of the friends written to by the DHR Chair was a close friend to both Martine and Adult B and gave a statement during the homicide investigation. At the request of the DHR Chair, the police Family Liaison Officer (FLO) made further contact with the witness to establish if they were prepared to engage with the review process. The witness did not wish to take part.

6.6. Further enquiries were made with the Police Major Investigation Team to see if they held any information on the friends of Adult B, but no details were held by them. Adult B did not provide any background information during his formal interviews with the police and answered 'no comment' to all questions asked. In addition, the family members of Adult B did not engage with the police during the homicide investigation.

7.0 CONTRIBUTORS TO THE REVIEW

7.1. The agencies who have contributed to this DHR are:

Southend Clinical Commissioning Group – Queensway Surgery (SCCG - IMR)
Essex Partnership University NHS Foundation Trust (EPUT-IMR)
Southend University Hospital NHS Foundation Trust (SUHFT-IMR)
East of England Ambulance Service. (IMR)
Essex Police (Report)
Southend Borough Council Adult Social Care (Report)
Southend Borough Council Children's Social Care (Report)
Essex Probation Service (Report)
South Essex Homes (Report)

7.2. Independence and Impartiality are fundamental principles of delivering Domestic Homicide Reviews and the impartiality of the Independent Chair and Report Author and panel members is essential in delivering a process and report that is legitimate and credible. None of the panel members, had direct involvement in the case, or had line management responsibility for any of those involved.

8.0 THE REVIEW PANEL MEMBERS

8.1. The panel for this review was made up of the following representatives;

Tracy Hawkings – Independent Chair and Report Author.
Imelda Callowhill – Lead Nurse, Safeguarding Adults – Southend Clinical Commissioning Group.
Tendayi Musundire – Head of Safeguarding - Essex Partnership University NHS Foundation Trust.
Paul Hodson – Associate Director for Safeguarding Services - Southend University Hospital NHS Foundation Trust (SUHFT).
Lynn Scott – Head of Southend Adult Social Care.
Sarah Conlon – Service Manager – Safe Steps, Southend Domestic Abuse Service.
Paul Hill – Southend Safeguarding Adults Board Manager.
Simon Ford – Head of Community Safety – Southend Borough Council.
Helen Brown – Police Inspector – Public Protection Command, Essex Police.
Michelle Williams – Domestic Abuse Co-ordinator – SETDAB.
Jacob Nurdan – Domestic Abuse Support Officer – SETDAB.

8.2. Responsibilities directly relating to the commissioning body, namely any changes to the terms of reference and the agreement and implementation of an action plan to take forward the recommendations within this report is the responsibility of the Southend Community Safety Partnership.

9.0 AUTHOR OF THE OVERVIEW REPORT

9.1. The Southend, Essex and Thurrock Domestic Abuse Board appointed Tracy Hawkings as DHR Chair and Overview Report Author on 28th May 2019.

9.2. Tracy is a safeguarding consultant specialising in undertaking reviews (Critical Incidents, Serious Case Reviews, Domestic Homicide Reviews and Past Case Reviews). Tracy previously served as an officer with Essex Police and has 30 years policing experience. During her service, Tracy was Head of the Crime and Public Protection Command, working extensively with partner agencies at a strategic level, including those working to deliver policy and practice in relation to domestic abuse. Tracy was previously, Head of

Major Crime and an accredited Senior Investigating Officer responsible for leading homicide investigations including domestic homicides.

9.3. Tracy retired from the police service in March 2017 but has spent the intervening time working in the field of Public Protection in Suffolk, Hertfordshire and for the National Safeguarding Team for the Church of England. She has not had any direct involvement with Southend agencies nor with the policies, practices or operational oversight of the resources deployed in this case since her retirement.

10.0 PARALLEL REVIEWS

10.1. An inquest was opened and adjourned by HM Coroner in Essex on 29th January 2019. Following the outcome of the criminal proceedings, the Coroner decided not to hold an Inquest, accepting the findings of the Criminal Court.

11.0 EQUALITY AND DIVERSITY

11.1. The review adheres to the Equality Act 2010 and all nine protected characteristics i.e age, disability, gender re-assignment, marriage and civil partnerships, pregnancy and maternity, race, religion and belief, sex or sexual orientation were considered by the panel as part of the terms of reference and throughout the review process.

11.2. Martine was a white British National. She was aged 40 years old at the time of her murder. When aged 21 years old, she gave birth to her only child from a previous relationship. Martine had other relationships with male partners before meeting Adult B. It has not been confirmed whether or not she ever married, but she did take the surname of a long-term partner who died in 2017.

11.3. As far as the panel has been able to determine, Martine did not hold any strong religious beliefs or have any language or acute learning needs which would have impacted on any assessments or the services offered to her.

11.4. The panel consider that Martine should be considered as vulnerable according to the organisational criteria based on national guidelines[2]. This is based on the fact; she had a history of mental health concerns and had been diagnosed with bi-polar disorder and emotionally unstable personality disorder (EUPD). She was under the care of a consultant psychiatrist and prescribed with various medications at the time of her murder.

11.5. Martine was in receipt of Employment Support Allowance (ESA). This is monetary support provided to an individual if they are in a position where they cannot work due to an illness or disability. In this instance, Martine was receiving ESA due to her diagnosis of fibromyalgia.

11.6. Research has revealed that women in poorer households were subject to more inter-personal violence than those in richer ones. This is very marked for domestic violence where women in households with an income of less than £10,000 were three and a half times more at risk than those in households with an income of over £20,000[3].

11.7. Sex should always be a consideration in DHR's. Sex is considered a risk factor as the overwhelming majority of victims of domestic abuse are female with the perpetrators being overwhelmingly male. Research has also shown that the majority of intimate partner homicides are disproportionately perpetrated by men on women. In 2019, 75% of the victims of domestic homicides were female[4].

11.8. A recent study of Domestic Homicide Reviews committed between 2011 and 2016 revealed that: "Of the 33 intimate partner homicide DHRs the majority (29) involved a male perpetrator and female victim(s)".[5]

11.9. The panel has found no evidence to suggest Martine was discriminated against either directly or indirectly by any of the statutory agencies with whom she came in to contact but may have encountered barriers to prevent her from accessing services based on her ill-health, gender and financial status.

[2] The Care Act 2014 – Section 42. The Care Act replaced "No Secrets" and the terminology used in the Care Act is adult with care and support needs who as a result of their care and support needs cannot protect themselves from abuse/risk of abuse/effects of abuse.

[3] Dr Sara Reis - Domestic Abuse is an Economic Issue For Its Victims and For Society – Published Dec 2019 Child Poverty Action Group.

[4] Office for National Statistics 2019

[5] Home Office (2016) Domestic Homicide Reviews: Key Findings from Analysis of Domestic Homicide Reviews

11.10. There is very little information held by professionals on Adult B. He is a white British National who was aged 32 years old at the time of the murder. During an interview with the Report Author he disclosed he had moderate learning difficulties and because of that was unable to hold down full-time employment. Adult B also disclosed he did not claim benefits and did casual work for cash in hand. He admitted to having a dependency on drugs and alcohol and was a frequent user of cocaine.

11.11. Within the information provided by professionals, particularly social care, there is no record of Adult B ever being formally assessed or diagnosed with learning difficulties. In August 2018, when he joined the GP practice, he disclosed to the practice nurse that he suffered with dyslexia.

11.12. Based on the information available to the review, there is no evidence to suggest Adult B was discriminated against either directly or indirectly by any of the statutory agencies with whom he came in to contact but may have encountered barriers to prevent him from accessing services based on his dependency on alcohol and drugs and his self-disclosed moderate learning difficulties.

12.0 DISSEMINATION

12.1. In accordance with Home Office guidance all agencies and the family of Martine are aware that the final Overview Report will be published. IMR reports will not be made publicly available. Although key issues if identified will be shared with specific organisations the Overview Report will not be disseminated until clearance has been received from the Home Office Quality Assurance Group.

12.2. The content of the Overview Report has been suitably anonymised to protect the identity of the female who was murdered, relevant family members and friends. The Overview Report will be produced in a format that is suitable for publication with any suggested redactions before publication.

12.3. The family of Martine will be provided with the final version of the Overview Report prior to publication.

13.0 BACKGROUND INFORMATION (THE FACTS)

13.1. Martine was born in Southend in 1978. Her mother, Adult C separated from the father of Martine before her birth due to the abusive nature of their relationship. Her mother brought her up for the first two years of her life, but due to her personal circumstances at the time, was unable to provide a stable home and so placed Martine in the care of her maternal grand- parents. It was they, who brought her up in a loving, stable environment until she was in her late teens. Adult C was a frequent visitor to their home and also had care of Martine for weekends and school holidays.

13.2. In later years, Adult C married and had other children. For a period of time, when aged in her late teens, Martine went to live with her mother, stepfather and half siblings. The arrangement did not work out and Martine moved out. Adult C has described this as a difficult period in their lives. From this point Martine lived independently of her family and had infrequent contact with her mother and stepfamily. She did maintain contact with her grandparents.

13.3. In 1998, when aged 21, Martine gave birth to her only child. The relationship with her baby's father ended and they separated. The couple had a joint residence order and shared custody of the child. At the time of Martine's murder, the child (now an adult) was living with her father.

13.4. Martine had other relationships. There was mention in the mental health service notes that she was married between 2002 and 2006, but separated from her husband, due to domestic abuse. Her family do not believe she ever married.

13.5. By 2010 (exact date unknown), Martine had a long-term relationship with Adult D, who was described by her family as the love of her life. Tragically, Adult D was diagnosed with terminal cancer and in 2017 died from sepsis which developed as a result of a dog bite. The incident with the dog, was witnessed by Martine who was traumatised by the event and subsequently devastated by the death of her partner[6]. There were reported suicide attempts following his death which are detailed within the chronology section within this report.

[6] Information provided by the Mother of Martine during interview with Report Author.

13.6. Martine met Adult B in March 2018 through a mutual friend. Their relationship developed quickly, and it was not long before Adult B moved into Martine's flat with her. The flat was rented from the local Housing Association[7].

13.7. During the afternoon and early evening of the fatal shooting (January 2019), Martine exchanged a number of "What's app" messages with a friend. The texts reveal that Martine was deeply unhappy and struggling to cope with the death of her previous partner. She wrote she was currently experiencing difficulties in her relationship with Adult B. The couple had recently split up, but Adult B had agreed to come back for a month's trial. It appears as though she was struggling with an addiction to alcohol and drugs which may have been an indicator of domestic abuse and a way of coping with it. The texts from Martine also detailed that Adult B was "out of his head on whisky and tramadol" consumed during the morning and had left the house following an argument[8].

13.8. At 19.12hrs the same day, Martine made a 999 call to police and reported a domestic abuse incident between herself and her boyfriend, Adult B.

13.9. The duration of the 999 call was 37 seconds, during which Martine reported that her boyfriend was in her house and was refusing to leave. She stated he was being quite aggressive (in what form this aggression was manifesting is not explained). Martine then informed the call taker that her boyfriend was leaving and requested that the police units were cancelled.

13.10. At 19.18hrs, the Ambulance service received a call from Adult B reporting he had shot Martine and himself.

13.11. Police and paramedics attended the home address of Martine and found her with serious shot gun injuries to her face. She was conveyed to Southend hospital and subsequently transferred to the Royal London hospital where she died of her injuries two days later.

13.12. Adult B had also sustained minor facial shot gun injuries. He was conveyed to Basildon hospital. He was arrested at the scene and a sawn-off shot gun was recovered by police. He admitted to the attending officers that he had shot Martine. He appeared unsteady on his feet and admitted to drinking an

[7] Information provided by Adult B during interview with Report Author at Woodhill Prison.
[8] Information provided by Review Officer for Essex Police – Report dated 24th July 2019.

excessive amount of alcohol and to taking cocaine and other drugs. He did not provide an account during his police interviews. He was subsequently charged with the murder of Martine.

13.13. During the police investigation, further enquiries were made in relation to the firearm found at the scene (a 12-gauge side by side hammer shotgun of Belgian origin). There was no direct match for the weapon on the National Firearms Licensing Management System and the weapon was not linked to any other criminality. Neither Martine nor Adult B held a firearms licence nor were any weapons ever registered to the address by any other party. The history of the weapon cannot therefore be established and would have been illegally held.

13.14. A forensic post mortem examination was performed on Martine. The cause of death was given as 'shotgun wound to the face'. There were also recent and healing injuries present which were not typical of assault or restraint immediately prior to death. Martine had sustained a fracture to her hyoid bone which could be consistent with strangulation or caused as a result of the shotgun injuries. The pathologist was unable to determine which was the cause of this.

13.15. Adult B pleaded guilty to murder at Basildon Crown Court in July 2019. He was sentenced to a minimum term of 26 years imprisonment. He did not appeal the sentence.

13.16. A Coroner's inquest was opened but adjourned pending criminal proceedings. At the conclusion of the Criminal Proceedings, H.M Coroner for Essex decided not to hold an inquest, on the basis she accepted the findings of the Criminal Court. This decision was not contested by Martine's family.

14.0 CHRONOLOGY

14.1. There is little information held by any of the agencies involved with regards to the dynamics of the relationship between Martine and Adult B. Similarly, during this period of time, Martine was estranged from her family and they were unable to provide any information in relation to Martine's contact with professionals.

14.2. The majority of the information held by agencies involved in this review is in relation to Martine. There is only a minimal amount of information available in respect of Adult B. The main agencies involved with either Martine or Adult B are EPUT, CCG (Queensway Surgery), Southend Hospital, East of England

Ambulance service and Essex Police. Some historical information is held by Southend Children's Social Care in relation to Martine and her child.

Combined Chronology

14.3. Martine was first known to Essex Partnership University NHS Foundation Trust (EPUT) between 2002 and 2004 when she was under the care of the Southend mental health team. She then became known to the services again in 2010 in relation to support from the psychology team following the terminal illness of her then partner. She was also under the eating disorder team for a short period of time. She was discharged from both teams later in the same year.

14.4. On 29th August 2008, Martine contacted police stating that she was at her ex-partner's parents' address in order to collect her child Her ex-partner arrived at the address, whilst she was there, and a verbal argument occurred regarding where the child would be staying that night. Police attended and the matter was resolved. No offences were disclosed.

14.5. On 11th August 2009, Martine contacted police stating that her partner, had moved out of her address and whilst doing so had smashed some of his own possessions following an argument. Police attended and established that no offences had occurred.

14.6. On 27th December 2009, Martine contacted police stating that whilst at a friend's house following her partner who had grabbed her by the dressing gown and shoved her against a wall. No injuries were caused. Police attended and the matter was subject of crime recording and an investigation. Her partner was arrested and interviewed following which no further action was taken.

14.7. In addition to the recorded domestic abuse incidents the police have five other records involving Martine between 2009 and 2014. These include three incidents where Martine was arrested and charged with public order offences, assault on police and theft (Shoplifting) and two incidents involving Martine being the victim of harassment.

14.8. The incident involving the assault on police, followed a call from ambulance to support them in attending a report of a female overdose as there was information to suggest the patient might be violent. Upon police attendance an officer sustained minor injuries, and Martine was arrested following her attendance at hospital.

14.9. Between 2011 and 2014, Martine had brief periods where she was under the care of the mental health team in Brentwood. She was clinically assessed in 2014 and the service concluded she no longer needed their support.

14.10. In 2016, Martine was in crisis and seen by the Southend Assertive Outreach Service. She was referred by them to the care of a consultant psychiatrist who saw her in outpatients the following month and then saw her regularly for support and monitoring up until the time of her murder.

14.11. In 2017 Martine enrolled in the recovery college. Recovery is a uniquely personal journey. It means giving people the power to live their lives with purpose, meaning and hope for the future. This service ran courses to enable service users to move away from diagnosis and illness towards good mental health and wellbeing.

14.12. On the 15th of March 2018, Martine was referred to and attended psychotherapy sessions. She was seen by the head psychotherapist and the goal of the sessions was to explore her feelings over the loss of her partner. Due to non-attendance she was discharged from the service. It was evident from the notes that Martine was keen to explore the way she felt and therefore she was referred back and seen by the psychotherapy team. Again, attendance was spasmodic and as this intervention required full attendance from the participant, she was discharged. The psychotherapist recalls that there was never any mention of domestic abuse discussed or mentioned at the sessions.

14.13. On 6th April 2018, Martine attended her GP surgery to see the practice nurse in connection with a minor infection. During the consultation, she informed the nurse, she had been widowed for over a year but was now in a new relationship. This is believed to have been with Adult B and was the first time any professional had been made aware of the new relationship. She disclosed her previous partner had died from sepsis following a dog bite. There does not appear to have been any exploration by the nurse as to how she was coping with the bereavement.

14.14. On the 20th June 2018, the electronic record identifies communication to the GP from the mental health team (EPUT) advising that Martine had attended psychiatric services for a medication review. The GP was

advised to carry on prescribing medications, but her antidepressants were changed to fluoxetine[9] and on the 12th of July 2018 Martine was seen by the GP for a medication review.

14.15. At 0542 hours on 6th August 2018, Adult B was conveyed to hospital by ambulance having presented with a query seizure. He denied taking any recreational drugs but admitted to taking 400mg of tramadol for his painful knee. History given by Adult B to paramedics was that he was having sex with his girlfriend, after which he went downstairs to go to the toilet and thinks he had a seizure. He referred to his 'wife' also having had a seizure shortly after he had his. He felt fine at time of medical review in the emergency department. He was discharged with his GP to refer him to the neurology clinic.

14.16. At 0550 hrs the same day, Martine attended the emergency department conveyed by ambulance crew following a seizure. The seizure was witnessed by the ambulance crew whilst they were attending her partner, Adult B. The attending doctors queried substance use, but Martine denied any recreational drug use. She described being well prior to the seizure but sustained a cut to head during the seizure. She was discharged and referred to her GP for follow up. During the assessment process, Adult B was referred to as Martine's main carer.

14.17. At 1149 hrs the same day, Martine re-attended the emergency department following 2 witnessed generalised seizures within the past 24 hours. The first seizure (described above) occurred after calling an ambulance because her partner was having a seizure. The 2nd seizure and subsequent admission occurred whilst Martine was being driven home by a neighbour. Martine denied excess alcohol intake. There was mention in the notes that the secondary seizure occurred due to the effects of a combination of alcohol and rat poison. Martine stated they had rat poison in the house due to an infestation of mice. Systemically she was well and her blood tests results were unremarkable. A spine and head CT scan showed no abnormality. The only recent change noted was the commencement of Martine on the drug fluoxetine. There was no acute kidney injury or sepsis. The first seizure occurred whilst ambulance crew were attending the property to see Adult B. Martine was transferred from the emergency department to a ward at 1600hrs on 6th August 2018. She was fully mobile but complaining of tiredness.

14.18. Martine had a neurology (brain) assessment on the ward which showed normal neurological functions. She denied taking rat poison. She had a small head wound as a result of a fall (witnessed). Martine was

[9] Fluoxetine is also known as Prozac and is an anti-depressant.

referred for further neurological review as an outpatient. Seizure safety advice was given. Martine was discharged from the ward on 7th August. A follow up appointment was arranged with neurology and an EEG[10] as an outpatient was completed and showed nothing abnormal. A letter was sent by SUFHT to Martine's GP practice.

14.19. At 1602 hrs on 8th August 2018, Martine attended the A&E department in company with her partner, Adult B. Martine gave a history of Adult B suddenly going stiff with up-rolling of his eyes lasting 2-3 minutes. He had a second episode about 2 hours later which was similar in presentation. He gave a past history which included cannabis (marijuana) use and a history of deaths in his family of brain tumours. The medical team noted, he had also attended on 6th August 2018. They referred him to the medical team, but he discharged himself without being seen by them.

14.20. Two weeks later on 21st August 2018, Martine was seen by the GP for a medication review. This was initiated following notification from SHUFT of the seizures on 6th August. The discharge letter to her GP stated that "the patient had had a seizure after calling the ambulance because her partner (Adult B) had also had a seizure". Martine had reported to the A&E Doctors, that she had recently re-commenced on fluoxetine. All tests were normal therefore she was discharged.

14.21. The GP recorded that Martine had no suicidal thoughts, maintained a good rapport and eye contact throughout the consultation. She was prescribed her medication and the GP sent a referral to her psychologist the next day.

14.22. On 13th September 2018 there was contact with the GP where Martine stated she had been better in herself with no suicidal thoughts. She reported she was generally better motivated and responding well to fluoxetine.

14.23. On 18th September 2018 Martine was seen by a GP for a repeat tramadol prescription, and on the 4th October 2018, there was a repeat prescription recorded on the electronic record for her sleeping tables, pain killers and anti-psychotic medication completed by her GP[11].

[10] An electroencephalogram (EEG) is a test used to find problems related to electrical activity of the brain. An EEG tracks and records brain wave patterns.

[11] Medication prescribed was zopiclone, tramadol, and aripiprazole.

14.24. On 18th October 2018 Martine attended the Queensway surgery for a routine health check and to have a Full Blood Check (FBC), to check for urea and mineral (electrolytes) and liver function tests.

14.25. On 6th December 2018, a GP contacted Martine by telephone following a concern raised with the surgery by a local pharmacy. The entry reads that concerns had been raised with the pharmacy by the boyfriend of Martine that she wanted to take all her medications at once. Martine informed the GP that she felt her mental health was stable and she was under the care of a mental health team and had an appointment in two weeks' time. Martine reassured the GP, she did not feel suicidal and thought the concern may have been raised by her boyfriend because they had argued. She informed the GP, she would contact them immediately to "report any change in her condition".

14.26. At 1848 hrs on 6th December 2018, Martine contacted the ambulance service reporting she had taken an overdose of tramadol and cocaine. During the call, a male (presumed Adult B) spoke to the call taker and informed them Martine was fine and did not require an ambulance. It was noted he tried to influence the ambulance service not to attend but this information was not passed on to the attending crew. A crew attended and conveyed Martine to the emergency department. Martine reported, she had had an argument with her partner and then took cocaine with 2 bottles of wine around 11am. Martine then took an overdose of tramadol, 300mgs in total. Patient was assessed on the Acute Medical Unit and left in for observations and to be assessed by the Rapid Assessment Interface and Discharge Team (RAID).

14.27. On the 7th December 2018, Martine was assessed by the Rapid Assessment Interface and Discharge Team (RAID)[12]. She had overdosed on her tramadol tablets having taken ten 200mg tablets and one 100mg tablet. Martine reported to the team that the trigger factor for the overdose was that she had lied to her boyfriend, about something she had done but would not discuss it further with the assessing nurse. According to Martine, Adult B had had found out about the lie and they had separated the previous night. Martine disclosed to the RAID team that her deceased husband had been violent towards her in the past but not her current partner, referring to Adult B. There had been two previous suicide attempts following the death of her husband. She denied any suicidal intentions on this occasion and indicated she wanted to return home. There was no disclosure of any risk from Adult B.

[12] RAID Team provides an in-reach psychiatric liaison service to prevent avoidable admissions to inpatient wards and mitigate longer lengths of stay associated with mental illness as a co-morbidity to physical conditions.

14.28. Martine disclosed that in response to Adult B leaving after the argument, she drank two bottles of wine and took cocaine, which she felt was out of character for her. She stated she would not have taken the overdose if it were not for the fact she was under the influence of alcohol and the illegal substance. The notes record, she had a history of overdoses following relationship breakups and this remains a trigger and risk factor for her. She also disclosed the second anniversary of the death of her previous partner was coming up in January 2019 and this would be a difficult time for her, albeit she felt she could cope. She also disclosed she was in debt and intended to seek the assistance of the Citizens Advice Bureau.

14.29. She stated that she took an overdose on the 6th December 2018 as she felt in a destructive mode at the time. She reassured the RAID team, she did not want to die and had lots of plans for the future. At the time of the overdose, she was worried that she would not be in a relationship with her partner, but this turned out not to be case, as they had since reconciled.

14.30. Adult B was present for part of the assessment. He was reported as being supportive but also tearful disclosing he struggled to understand Martine's condition of EUPD. As part of the release plan, he agreed to attend an EUPD course with Martine to increase his understanding of her condition.

14.31. The assessment stated: - "Martine is a 40-year-old female with a history of contact with mental health services. Has current diagnosis of EUPD and historical diagnosis of bipolar affective disorder. She has a history of overdoses following relationship break ups and this remains a trigger and risk factor for her. The medical release plan detailed the following:

- Martine was fit for discharge.
- She was to attend an outpatient's appointment on the 14th December 2018 with her psychiatrist.
- Contact number for CRUSE[13] given for there had been a discussion about bereavement and Martine felt bereavement counselling may be of use.
- They discussed attending the recovery college but Martine did not want to engage with this.
- Martine and Adult B plan to attend EUPD course provided by SAVS.
- Martine agreed to make contact with her mental health team if she had any suicidal feelings. She was also provided with the crisis line and Samaritans number.

[13] CRUSE – Charity set up to support bereaved people in England, Wales and Northern Ireland.

14.32. On 7th December 2018 Southend University Hospital NHS Foundation Trust (SUHFT), A&E department communicated by letter to Martine's GP advising that Martine had attended on the 6th December following an overdose of alcohol and medication pills. The letter gave detail in relation to her assessment and the fact she was admitted overnight and assessed by the hospital psychiatrist.

14.33. On 10th December 2018 Martine and Adult B attended the surgery together and were seen by a GP. During the consultation, Martine reported she had lost her medications and wanted another prescription for zopiclone which is a sleeping pill. There appears to have been no consideration given to the fact, she had taken an overdose only four days before. She also stated that she wanted to discontinue with tramadol which she had been taking for 15 years. The GP record states that Martine's mood was stable; she had no suicidal ideation and appeared calm. There does not appear to have been any in depth exploration by the GP in relation to the reason (s) for the overdose which involved Martine taking excessive tramadol in combination with alcohol and other substances.

14.34. On 14th December 2018, Martine attended an outpatient's appointment with her psychiatrist. During the appointment the incident on 6th December was discussed and the psychiatrist recorded that Martine stated, "all is well and that the argument has made the relationship stronger". The notes record the fact that Martine and Adult B were planning to attend an EUPD course provided by the Southend Association Voluntary Sector (SAVS)". There is a letter on Martine's GP record advising that she was seen at the outpatient psychiatric clinic on 14th December 2018 and she was to continue with prescribed medications but to stop taking her anti-psychotic medication[14]. Martine was seen that day at the surgery by the practice nurse. She presented with cold symptoms, breathing problems, and was taking asthma medications.

14.35. On December 19th, 2018, Martine was seen by a GP, she was requesting to be weaned off tramadol, stop dihydrocodeine and to have pregabalin[15] 50mg prescribed to control her fibromyalgia.

14.36. The following day on December 20th, 2018, Martine had a telephone conversation with a GP. The GP had contacted her after reading the letter from the hospital notifying them that Martine had taken an overdose of tramadol 2 weeks before (6th December), was taken into hospital and seen by the mental health team, and a psychiatrist. Martine advised that she now regretted her action, and that she had

[14] The anti-psychotic medication was apriprazole

[15] Pregabalin is a drug prescribed to treat anxiety and epilepsy.

done this following a "tiff with her partner". She stated that Adult B mentioned he was leaving her and that this caused the acute reaction. She reassured the GP, that she now had no intention of taking her own life. The GP requested she attend the surgery for an appointment in two weeks' time or sooner if she had any thoughts of suicide or self-harm.

14.37. 11 days later on December 31st, 2018, Martine attended the Queensway Surgery and was seen by a GP. She requested increase in dosage of pregabalin. She stated her mood had improved and she was less anxious and not feeling suicidal. Martine did not attend the follow up appointment with her GP arranged for January 2nd, 2019.

14.38. On January 7th, 2019, there was a telephone consultation between a GP and Martine recorded on the electronic record. Martine reported that she has lost her medications and required more pregabalin; therefore, a repeat prescription was provided.

14.39. The following day on January 8th, 2019 Martine requested additional propranolol[16] 40mg which is recorded on the record as having been prescribed.

14.40. On January 11th, 2019, Martine had an appointment with a GP at the surgery where she expressed concern that her medications were now being prescribed on a weekly rather than monthly basis and the fact, she had not received any communication as to the reasons why. She reported she had stopped taking tramadol for her fibromyalgia which had been diagnosed 15 years ago; and that the multiple painkillers she was on, were having no effect. She stated the pain from her fibromyalgia was not helped by taking 75mg pregabalin twice daily, and she wanted to see if increasing the dose might be helpful. The record states that her mood has been low since she lost her partner following a dog bite and sepsis 2 years before. She has been affected by anxiety and low mood and was currently under the mental health team with 6 monthly reviews. The notes record "She feels the tramadol overdose was a one off and does not feel suicidal".

14.41. In response, the GP apologised to Martine for any miscommunication regarding the weekly scripts and, explained that this had been put in place following the letter from the mental health team giving detail of her overdose on 6th December, (letter dated 12th of December 2018). The GP explained this action

[16] Propranolol is a drug prescribed to treat anxiety and migraines.

was routinely put in place to ensure patient safety and was not personally directed at one person. The record shows that Martine understood why this was the safe thing to do and was happy now that the explanation had been clarified. Martine expressed a wish for the GP to consider issuing 28-day scripts as before, as she felt it would be possible to control her medication intake. She reported her current partner helped with her medication, and she was tolerating medication well with no reported side effects. The GP agreed to review the situation in 4 weeks and advised her to report immediately if there was any deterioration in her mental health. This is the last contact that Martine had with her GP and the surgery prior to her homicide.

14.42. This was also the last contact any professionals had with Martine or Adult B before the call to emergency services days later.

14.43. There was other information provided by Southend Adult and Children's Social Care, Essex Probation Service and Department of works and pensions which fall outside of the timescales for this review and do not contain any information which the panel considered as relevant.

Information provided by Adult B

14.44. As part of the DHR, the Report Author visited Adult B in prison and had a meeting with him. The meeting was arranged at his request following receipt of letter sent by the DHR Chair on 2nd June 2019. The information detailed in paragraphs 1445-51. were provided by the perpetrator and given from his perspective.

14.45. Prior to meeting Martine, Adult B admitted to being a frequent user of cocaine and marijuana. He described Martine as having in his opinion an addiction to cocaine and some of her prescription drugs particularly zopiclone and tramadol.

14.46. Adult B stated he suffered with moderate learning difficulties and for this reason never gained full time employment. He did a number of casual jobs for cash in hand. He stated, before meeting Martine he either lived at home with his mother or sofa surfed with casual acquaintances. He described himself as a bit of a loner.

14.47. Adult B stated that he and Martine were both frequent users of cocaine, which they used to take in combination with alcohol and Martine's prescribed drugs. He admitted to frequently taking Martine's

prescription drugs, particularly tramadol. He said, the system made it very easy for them to access larger amounts of prescription drugs that she had been prescribed. He said Martine would frequently report lost medication to her GP or pharmacist and would always be prescribed with more, without any real challenge. They would also increase the prescription drugs available to them by ordering them from the internet. He admitted to having a dependency on tramadol and believed this was the cause of the seizures that both of them suffered in August 2018.

14.48. Adult B said he had very little recollection of the day of the shooting. He had taken cocaine the day before and on the day itself, and was heavily under the influence of alcohol and tramadol. He stated he had argued with Martine but he could not remember what about. He could offer no explanation as to his actions. He admitted that the firearm used in the incident belonged to him and that it had been in the flat for some time. He could not remember making the 999 call to the ambulance service or being aware Martine had made a 999 call to the police just minutes before.

14.49. Adult B spoke about the effects of legal and illegal drugs and believed they had been a contributory factor which influenced his behaviour.

14.50. It is known from information from professionals that following her overdose on 6th December, Martine reported the loss of prescriptions on two occasions. She also attended the GP surgery to ask for increased dosage of her prescribed medication. It is not known whether or not she did this under duress and at the instigation of Adult B, but there does appear to be an escalation in contact with the GP surgery following her overdose and in the days before her murder. Certainly on the basis of information provided by Adult B, it is now known he was a frequent user of medication prescribed to Martine and had an addiction to tramadol.

15.0 OVERVIEW

15.1. The overview will summarise what information was known to the agencies and professionals involved with Martine and Adult B during the period under review. It will also include any relevant facts or information known about Martine.

15.2. The agencies that had the most contact with Martine during her adult life were her GP surgery and EPUT (Mental Health Team). She was diagnosed with bi-polar disorder and EUPD for which she was prescribed anti-depressants and anti-psychotic drugs. She also had fibromyalgia for she was prescribed a powerful pain killer (tramadol) for a number of years.

15.3. From information received from her family and professionals, it is clear Martine was deeply affected by the challenges she faced with her mental ill-health. She also suffered with fibromyalgia which is a debilitating and painful condition. She was described by her mother as deeply troubled and her mother found it difficult to maintain a relationship with Martine during her adult years.

15.4. Martine was the victim of domestic abuse whilst in a relationship with two of her previous partners. There was a history of suicide attempts following the tragic death of a long-term partner in 2017. It was known she took her prescription drugs in combination with alcohol and cocaine.

Overview of involvement from Queensway surgery.

15.5. The Queensway surgery covers a very busy area of Southend and has a practice population of over 20,000 patients. Information published by Public Health, England rates the level of deprivation within the practice population area as level two on a scale of one to ten with one being the highest level. The Queensway surgery has a high percentage of patients presenting with mental health issues in addition to drug and alcohol health and lifestyle related issues. The medical staff include eleven GP's, six nurses and three health care assistants in addition to 2 home visit nurse practitioners, receptionists and administrative staff.

15.6. The information provided by the CCG revealed that Martine had good levels of engagement with the practice. She had a number of diagnosed medical conditions which included fibromyalgia, asthma, depression, bi-polar disorder and emotional unstable personality disorder (EUPD). She was prescribed

medication for her conditions which included a combination of painkillers, sleeping pills, anti-psychotic drugs and drugs for anxiety[17]. Some of the prescription drugs were prescribed by the GP and others by her consultant psychiatrist at Essex Partnership University Foundation Trust (EPUT).

15.7. During the period under review, April 1st, 2018 to January 2019, Martine had contact with her GP surgery on 17 occasions. She attended the surgery for 7 appointments with a GP and had 5 telephone consultations. During this time she had contact with seven different GP's at the surgery in connection with her medical conditions. In addition she saw the practice nurse on 5 occasions for routine tests or for smoking cessation advice.

15.8. In her contact with GP's at the surgery, Martine discussed her physical health needs as well as factors that were impacting on her emotional wellbeing. Pain management in terms of her fibromyalgia was a key issue, and this featured in five of the consultations. Martine requested a change of medication for pain management, when she felt it was no longer having an effect, and this was discussed and accommodated by the GP. In addition, she had a number of appointments linked to medication reviews, requests to change medication or reported losses of medication.

15.9. Martine discussed emotional issues with the practice nurse and doctors at the surgery. In April 2018, she reported to the practice nurse, the death of her long-term partner the year before and advised that she was now in a new relationship.

15.10. During telephone consultation that Martine had on 20th December 2018, she told her GP that she had taken the overdose because she had a "tiff" with Adult B after which, he told her, he was leaving. During this call, Martine provided reassurance that she regretted her actions. She was given a two- week follow-up appointment and given the opportunity to contact the surgery if she needed to attend sooner. However, this could have been an opportunity to probe further into the dynamics of the relationship.

15.11. On the 31st December 2018, Martine was seen by the GP, and although the GP records that Martine said she was no longer suicidal and was less anxious, this contact could potentially be considered another opportunity to discuss her relationship with Adult B and to determine or exclude indications that there may have been conflict or, that she might have been at risk from Adult B.

[17] The medication prescribed was tramadol, zopiclone, omeprazole, propranolol and pregabalin.

15.12. On 11th January 2019, she discussed with her GP, her suicide attempt which took place on the 6th December 2018 and was caused through an overdose on prescription drugs (tramadol), and cocaine and alcohol which resulted in admission to hospital. This incident took place whilst she was in her new relationship with Adult B; however, there is no evidence in the patient record that the GP explored this relationship with Martine or any evidence of routine questioning about domestic abuse in her relationship with Adult B, or any other vulnerability factors. This aspect has been followed up by the IMR author with the attending GP. The GP stated that she remembered the consultation well. Martine presented as calm and rationale. She provided a high level of reassurance about the status of her relationship with Adult B and spoke about him in favourable terms. She told the GP, Adult B looked after her and helped her with her medication management. The GP did ask general questions around domestic abuse but formed the opinion, Martine did not require a domestic abuse referral.

15.13. There is research evidence of a direct correlation between domestic abuse and poor mental health, particularly in female victims, and a significant proportion of people accessing mental health services have experienced abuse[18]. NICE guidance dictates that health practitioners should incorporate this into their assessments to increase identification and disclosures of domestic abuse in patients[19]. There is no evidence in the patient electronic record that domestic abuse was explored or discussed with Martine.

15.14. There is evidence within the clinical record that Martine was considered a vulnerable adult in light of her suicide attempt within the context of a known psychiatric diagnosis, the variety of controlled drugs that she was prescribed, her physical and emotional health issues, and her inconsistent compliance with taking her medication. Martine had reported twice that she had lost her medication following her overdose on 6th December 2018, and she advised the GP in during her appointment on January 11th 2019 that her partner helped her with her medication; this portrays a somewhat chaotic approach to her medication management by her and her partner which the GP could have explored further.

[18] Howard, L.M., Trevillion, K., Khalifeh, H., Woodall, A., Agnew-Davies, R., & Feder, G. (2010). Domestic violence and severe psychiatric disorders: prevalence and interventions. Psychol Med; 40(6): 881–93.

[19] Public health guideline (PH50) Domestic violence and abuse:multi-agency working. Published date:26 February 2014

15.15. There were six occasions between 10th December 2018 and 11th January 2019 where Martine either visited the surgery for a GP appointment or spoke to a GP on the telephone. The consultations included the two reported losses of medications and additional requests for increased dosages of her medication. These presentations should have been identified as a potential problem by the surgery particularly in light of the fact, Martine had taken an overdose on 6th December. The GP surgery only moved to weekly prescriptions following notification of the overdose from the mental health service but despite this, continued to prescribe additional medication to her. The DHR Panel acknowledge there is a difficult balance between looking after the clinical needs of a patient who has a condition which is extremely painful and their emotional needs and reliance on powerful medication. This aspect might have been further explored within her medicine management reviews with the GP, particularly as she used her medication in her suicide attempt. There was no consideration given to the fact that the increased requests for medication may have been an indicator of abuse or at the very least an increased dependency on powerful medication.

15.16. Martine was additionally accessing mental health services and received assessments and specialist input for anxiety and depression. Her clinical record states that her mood was consistently improved, that she was less anxious and had no suicide ideation. Mental Health Services liaison with the GP through consultant letters and other health practitioner entries onto the clinical record following assessments and interaction with Martine is evident.

15.17. The IMR author has provided reassurance to the DHR Panel that this practice does routinely question around the risk of domestic abuse and other risks in their screening and assessment processes with patients. Martine engaged well with practitioners at the surgery and was provided with a significant amount of support from them but the fact remains they should have picked up on the escalation of contact with Martine following the overdose of 6th December and her reports of lost medication and requests for increased dosages of prescribed medication.

Overview of EPUT involvement.

15.18. The Essex Partnership University NHS Foundation Trust (EPUT) provides community health, mental health and learning disability services for a population of approximately 1.5 million people in their own homes, and from a number of hospital and community-based resource centres and other community facilities.

15.19. Martine had been known to the service since 2002. She had an historical diagnosis of bipolar disorder and a more recent diagnosis of emotional unstable personality disorder (EUPD). EUPD is a disorder which interferes significantly with an individual's ability to regulate emotions, establish and maintain healthy relationships and make appropriate decisions. It can also be known as borderline personality disorder. This condition typically causes individuals to experience intense and fluctuating emotions, which can last anywhere from a few hours to several days at a time. These emotions can range from extreme happiness, euphoria and self-belief, to crushing feelings of sadness and worthlessness within the same day. In addition, it is not uncommon for individuals with EUPD to also experience suicidal thoughts and engage in self-harming behaviours. The rapid and extreme fluctuations in mood that are associated with EUPD can often make it difficult for sufferers to maintain stable personal relationships. Symptoms of EUPD include impulsivity, mood swings, an overwhelming fear of abandonment, extreme anxiety and irritability, anger, paranoia and being suspicious of other people, feeling empty, hopeless and worthless, suicidal thoughts, self-harm. It is not uncommon for sufferers of EUPD to have a pattern of unstable or shallow relationships[20].

15.20. The recordings on the notes held by EPUT offers very little insight into the relationships between other agencies and Martine. There is evidence of reactive practice between the services within EPUT which included preventable approaches to her illness, especially in psychotherapy where the emotional response was looked at in relation to her condition. She was appropriately referred for psychotherapy for her EUPD but there seems to have little consideration given to seeking the views of her partner or wider family and how they felt her condition impacted on her or them.

15.21. Interaction between EPUT services focused on her condition, when in hindsight possibly questioning her home life may have highlighted new information. At no point during her interventions with EPUT was alcohol intake or reactional drug taking recorded and therefore was not seen as a primary or secondary service issue. Therefore, no referrals were made to any agency for substance misuse support.

15.22. Multi-disciplinary approaches to intervention should be encouraged as should greater communication between the other agencies involved. Whilst there is no recording of a multi-agency approach within

[20] Source – IMR from Essex Partnership University NHS Foundation Trust

EPUT there is also no evidence of EPUT approaching other agencies that may have had involvement with Martine.

15.23. On the 7th December 2018, Martine was seen by the RAID team at Southend Hospital A&E department. The assessment was full and well documented. Martine showed remorse for the overdose. She said she had argued with her boyfriend because she had been caught telling a lie (She never told staff what the lie was). Maxine said the fact she had consumed two bottles of wine and had taken some cocaine had been a factor in the overdose. Martine told professionals, this was out of character for her (referring to the alcohol and cocaine). Martine confirmed the reason she had taken the overdose was due to the fact that she had split up from her partner. By the time the assessment took place, Martine had reconciled with Adult B who attended A&E and was also present for part of the assessment process. At no point during the assessment process, was abuse within the home specifically discussed despite the well documented links between domestic abuse, mental health, and substance misuse issues. Adult B had also disclosed, he struggled to cope with Marine's EUPD. A potential barrier to Martine making any disclosures was the fact Adult B was allowed to be present.

15.24. The DHR Author has sought additional information from the Head of Safeguarding for EPUT during the review process. He said he had reviewed the RAID notes himself and confirmed the practitioners had tried to explore at length the potential risks to Martine including domestic abuse. Martine presented that the overdose was an impulsive act whilst she was already under the influence of alcohol and cocaine and in response to her relationship with Adult B coming to an end. She informed practitioners that they had since reconciled and downplayed any concerns relating to any further occurrences of self-harm, which is not uncommon. The initial assessment in A and E was conducted whilst Martine was still under the influence of the substances she had taken. Arrangements were made for a follow up more detailed assessment the following day. All assessments within EPUT are designed to explore potential risks to the patient and then followed up in subsequent outpatient appointments as part of a patient's on-going care.

15.25. The EPUT IMR author met with the consultant psychiatrist as part of the review process. The consultant reported, that at no point in his interactions with Martine, had there ever been mention of violence or abuse within the home or with her new partner. He reported that Martine was able to ask for help and was not seen as vulnerable adult in this accord. In respect of liaison with other agencies there was not seen to be the need as there was no history of violence or abuse. There was acknowledgement by the IMR author that questions throughout her interventions with the teams were all about the way she felt

and coping skills but there was no evidence of questioning documented on possible domestic abuse or any consideration given to the impact her condition might have on her partner or family.

15.26. There were no signs of illegal drug usage identified and it was never disclosed. He is aware that years ago there was mention of cannabis (marijuana) use for recreational purposes but nothing since. When Martine was seen on the 14th December 2018 it is noted that she stated that "all is well and that the argument has made the relationship stronger".

Overview of Involvement of SUHFT

15.27. Southend University Hospital NHS Foundation Trust (SUHFT) provides acute services from its main Southend Hospital Site and satellite centres across Southend-on-Sea, Castlepoint and Rochford. The Trust employs over 4,500 staff and serves a population of over 350,000.

15.28. The Trust provides a comprehensive range of acute services including acute medical and surgical specialties, general medicine, general surgery, orthopaedics, ear, nose and throat, ophthalmology, cancer treatments, renal dialysis, obstetrics and gynaecology and children's services.

15.29. Martine had 4 contacts and Adult B two contacts with SUHFT during the period under review.

15.30. In relation to the series of hospital admissions of both Martine and Adult B between 6th to 8th August 2018, the notes do not indicate any further questioning into the underlying causes of why they both suffered with simultaneous seizures. During the medical assessment, Martine described herself as a social drinker and denied recreational drug use. She was prescribed medication as a treatment for alcohol withdrawal. (The panel has established that this is standard procedure for someone who has presented as having taken an overdose combined with excess alcohol being a factor). The notes do not refer to any further enquiry into her claim that she was a social drinker and the possible need for alcohol support services. This may have offered further insight into her lifestyle and potential risks. Although alcohol and drug use were covered within the assessment, there is no evidence of challenge when drugs and alcohol use was denied.

15.31. Adult B was examined by Doctors. He admitted to a history of cannabis (marijuana) usage but there does not seem to have been any enquiry as to his usage of tramadol which is a prescription drug which was not prescribed to Adult B but was prescribed to Martine.

15.32. Overall the panel were concerned that there was little evidence of professional curiosity or further enquiry into the history provided by Martine and Adult B. Although alcohol and drug use were covered within their respective medical assessments, there is no evidence of challenge or enquiry around their use or possible role in their simultaneous seizures. The lack of professional curiosity may have been a barrier to both Martine and Adult B disclosing the full extent of their dependency on drugs/alcohol.

15.33. In relation to Martine's attendance at A& E on 6th December 2018, Martine referred twice to an argument with her partner during assessments. There was no further enquiry into this at the time by the practitioners involved. Martine then did not disclose any further information, the following day, during her assessment with the RAID team. This could have been a missed opportunity.

15.34. Domestic Abuse Services were not offered to Martine, despite the fact the Trust did, at the time, have a hospital based Independent Domestic Violence Advocacy Service provided by Safer Places and information about domestic abuse services is displayed within the department promoting the domestic abuse services at that time as a reminder to staff.

15.35. A referral pathway was in place with a hospital based Independent Domestic Violence Advocacy Service available. The Trust also has a Safeguarding Service. No referral was received for Martine. Although she did not disclose domestic abuse beyond a reference to an argument, further enquiry and appropriate questioning may have encouraged further disclosure.

15.36. The argument with her partner was not referred to by Martine on the 7th December 2018 in any detail and no abuse or harm was disclosed. The review author has discussed this aspect with the Safeguarding Lead for EPUT who said it is not unusual for disclosures around domestic abuse to be altered by a patient when they are no longer under the influence of intoxicating substances or in a heightened emotional state. However it was still not clear if this was explored further.

15.37. According to the SET Safeguarding Guidelines April 2019, professional curiosity is the capacity and communication skill to explore and understand what is happening within an adult rather than making assumptions or accepting things at face value. Professional curiosity can require practitioners to think 'outside the box', beyond their usual professional role, and consider circumstances holistically. Curious

professionals will spend time engaging with adults. They will ask questions (in an open way) and seek clarity if uncertain and will be open to the unexpected"[21].

15.38. Although there was no disclosure of domestic abuse during the hospital assessments on 6th and 7th December, the DHR Panel would suggest there may have been opportunities missed to explore the answers provided during assessments and that responses provided at that time had been taken at face value.

15.39. In addition, the presence of Adult B when Martine was being assessed in both A&E and by the RAID team between 6th and 7th December 2018, may have been an indicator of controlling behaviour on his part which might have inhibited Martine speaking freely. It is normal practice that family members would be asked to wait in the waiting area during the assessment. However, the IMR Author was unable to confirm the reasons as to why he was allowed to be present.

Overview of involvement with East of England Ambulance Service

15.40. The East of England Ambulance Service (EEAS) NHS Trust was formed on July 1, 2006 with the merger of ambulance services covering Bedfordshire and Hertfordshire, East Anglia and Essex. It covers an area of 7,500 square miles and responds to over one million emergency calls each year.

15.41. During the period under review EEAS had five contacts with Martine and Adult B including attendance on the night of the murder. These included attendances following report of seizures where both parties were conveyed to hospital between 6th and 8th August and Martine's overdose reported on 6th December.

15.42. The only area of comment to note for the East of England Ambulance Service is their initial handling of the incident on 6th December 2018, when Martine made a 999 call to the ambulance service reporting she had taken an overdose. During the call, a male person came on to the phone and tried to cancel ambulance attendance reporting Martine was fine. This information was not communicated to the attending crew or to the A&E medical personnel. This is of significance, when you consider the reasons given by Martine for taking the overdose and may have prompted further questioning with regards to their relationship. This may have been an indicator of Adult B's controlling behaviour.

[21] SET Safeguarding Guidelines April 2019 – Chapter 3.1

Overview of involvement with Essex Police.

15.43. Essex Police is one of the largest non-metropolitan Police Forces in the UK. It serves a population of over 1.5 million residents over a geographical area of 14000 square miles. It has a membership of nearly 3000 officers.

15.44. The police had historical dealings with Martine outside of the period under review which included three reported domestic abuse incidents involving two ex-partners' of Martine and a report of harassment involving a male friend of Martine's ex- partner.

15.45. The police had significant involvement in the investigation of the murder in January 2019 but had no dealings with either Martine or Adult B during the period under review.

15.46. The area of comment for Essex Police is in their handling of the 999-call made by Martine on the day of her homicide whereby she reported a domestic abuse incident between herself and her partner. It is stressed by the review panel that the subsequent homicide within minutes of this call could not have been prevented, but it does set out what learning can be identified and whether any changes to the current process should be considered.

15.47. The call at 19.12hrs on the day in question was 37 seconds long during which Martine stated that her partner was in her house and was refusing to leave and was being quite aggressive (in what form this aggression was manifesting is not explained). Martine then stated that her boyfriend was leaving and not to worry about it and to cancel the police attendance.

15.48. The FCR call taker assessed the call as a domestic abuse Incident and graded the call as Priority 1 (Emergency Response Urban within 15 minutes). The incident was tagged for the Assessment Centre and the incident transferred to a dispatcher.

15.49. At 19.16hrs an FCR Supervisor reviewed the incident and downgraded the incident to a Priority 3 (Priority Response within an hour) and placed a THRIVE[22] assessment on the incident explaining their rationale. This process was in accordance with current Force Policy.

[22]Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services – Thrive Risk Assessment, is a risk assessment tool used by forces. It stands for Threat, Harm, Risk, Investigation Opportunities, Vulnerability of the victim and the Engagement level required to resolve the issue. The elements are used to assign a priority level to an incident. It may also be used to reach and justify an operational decision. Last updated April 2014.

15.50. At 19.17hrs, the Ambulance service received a call from Adult B reporting the shooting.

15.51. In this case the Review Panel has considered the downgrading of the incident by the Police from a Priority 1 to 3 and makes the following two observations:

1. The circumstances of the incident had not changed between the initial grading by the call taker and the regrading by the FCR Supervisor.

2. Staff within the FCR were unable to regain contact with Martine after the initial call was terminated.

15.52. The response grading of incidents will always be the subject of the individual judgement of call takers and supervisors within the FCR based upon the information presented to them at the time. In this case the initial assessment by the initial FCR call taker was appropriate.

15.53. However, the subsequent THRIVE assessment conducted by the FCR Supervisor leading to the downgrading of the response did not articulate in detail what change in circumstances had occurred to warrant the regrading from 1 to 3. The Essex Police response to emergency calls is set out within Force Policy[23] and Procedure[24].

15.54. Those members of staff in first contact with a caller should conduct a risk assessment in accordance with the THRIVE principles. The THRIVE risk assessment model has been identified by the HMICFRS[25] as best practice to assist operational staff to identify Threat, Harm, Risk, Investigative opportunities, Vulnerability and Engagement opportunities more quickly and resolve issues at first contact. The outcome of this assessment will determine the level of response to any given incident based upon the information provided by the caller.

15.55. For those incidents identified as domestic abuse Incidents there is an additional level of assessment of risk which is provided by the Assessment Team within the Crime and Public Protection Commands Operational Centre as set out in Force Procedure[26].

15.56. All reported domestic abuse incidents are automatically tagged to the Assessment Team who perform intelligence checks on those parties named within the incident and the address to which the incident is

[23] Essex Police Policy D 0500 - Incident Command and Control (date Published 07/02/2017)
[24] Essex Police Procedure D 0503 – Responding to Incidents (date Published 07/02/2017)
[25] Her Majesty's Inspectorate of Constabulary, Fire and Rescue Service – Thrive Risk Assessment
[26] Essex Police Procedure B 1701 – Domestic Abuse Initial Grading and Attendance (date Published 06/10/2017)

linked. This is a process designed to help inform the Force Control Room (FCR) and those officers in attendance at domestic incidents of any heightened risk around those involved in the incident. These checks are prioritised in accordance with the initial response grading's with the results being placed on the STORM incident for the attention of the FCR who relay any relevant information to the attending officers. These assessments can either result in the response grading being raised or lowered.

15.57. Where a response grading is changed as a result of the update from the Assessment Centre or new information comes into the FCR from the informant/member of the public a clear rationale must be documented within the STORM incident for doing so utilising the THRIVE model.

15.58. An incident initially graded as either a Grade 1 or Grade 3 can only be downgraded by a FCR Supervisor.

15.59. The review panel considers that the regrading from 1 to 3 was premature given the nature of what was being reported by Martine coupled with FCR Staff being unable to make contact with her after she had ended the initial call.

16.0 ANALYSIS USING THE TERMS OF REFERENCE

16.1. This part of the review will examine how and why events occurred, information that was shared, the decisions that were made, and the actions that were taken or not taken. It will consider whether different decisions or actions may have led to a different course of events. The analysis section seeks to address the terms of refence and the key lines of enquiry within them. It is also where any examples of good practice are highlighted.

16.2. This analysis considers the previous sections within this report and the content of the IMR's, including the chronology of events.

16.3. It is important to repeat this review is not into the cause of Martine's murder, but in answer to the terms of reference. The purpose of the review is to examine the contact Martine had with services and analyse whether those services were appropriate and whether there are lessons to learn from her homicide.

16.4. There is no information recorded in any of the participating agency files or as a result of interviews with the professionals who came in to contact with Martine or Adult B to indicate that there were any issues relating to domestic abuse between them prior to Martine's attendance at hospital on 6th December 2018. There is very little information held by any agency in respect of Adult B or the dynamics of the relationship with Martine.

16.5. The Review Panel has identified four areas of concern which will be addressed in this section and has also identified areas of good practice.

Areas of Concern.

16.6. Firstly, both Martine and Adult B were taken to hospital on 6th August 2018 following reports of "spontaneous" seizures. Adult B re-attended on 8th August following further seizures. They were both provided with adequate clinical care; however, further time could have been spent by the professionals involved enquiring into the causes of this unusual event. The panel are of the view that there was sufficient information given by one or both of them to raise suspicion in relation to their alcohol and drug intake.

16.7. Secondly, when Martine was admitted to hospital on 6th December 2018, following her overdose, she disclosed the reason she took a combination of drugs and alcohol was because she was so distressed because of an argument with her partner. Again, although adequate clinical care was given and an appropriate referral made to the RAID team, more time should have been spent with those entrusted with her care being professionally curious and exploring the dynamics of the relationship between Martine and Adult B. Adult B was present in A&E and for part of the RAID team assessment and articulated to the medical practitioners, he struggled to understand and cope with Martine's mental health condition. There are two issues here which need to be addressed. Firstly, Adult B was allowed to be present for the medical consultation and assessment with Martine and this may have inhibited her ability to speak freely. Secondly, Adult B became distressed during the consultation and said, he found it difficult to cope with Martine's condition which could have explored more. However, the couple were referred to attend a course on EUPD to increase his understanding of her condition.

16.8. There was good communication from both the hospital and mental health services with the GP practice with regards to clinical care, but none of the professionals involved explored in any detail, the dynamics of the relationship or the risk factors involved.

16.9. The third area of concern is the prescribing of additional medication following the reported overdose of Martine on 6th December. On the 10th December, she attended the surgery together with Adult B and said she had lost her prescription drugs and wanted a further prescription for zopiclone (a sleeping pill). On 19th and 31st December 2018 Martine attended the surgery and was prescribed increased dosage of pregabalin, used to treat her anxiety. On 7th January 2019, she contacted the GP surgery reporting she had lost her prescription and was subsequently prescribed additional pregabalin. On 8th January 2019, Martine telephoned the surgery and requested additional propranolol (used to treat anxiety) which was also prescribed. This is an area of concern that a patient who has recently taken an overdose can be prescribed further medication by medical practitioners, especially in the wake of a recent suicide attempt following a domestic argument.

16.10. The DHR Panel consulted with the Head of Medicines for Castlepoint, Rochford and Southend CCG's on this point. The expert was asked to comment on the issue of reporting lost prescriptions following an overdose. The expert stated that this is difficult question to answer as the clinicians who engaged with Martine would have made a decision reviewing risk vs benefit rationale based on the narrative presented and information available. The expert, reported, however, it is reasonable to assume that Martine should have been challenged and any concerns noted, and shared with relevant colleagues involved in her care. This can be difficult in practice depending on where she presented to. For example, most GP practices should be able to track an electronic prescription to see it has been dispensed before issuing a new prescription. A community pharmacy will only be able to track if they have a bar code and out of hours settings are currently unable to track prescriptions. The clinician must consider the risks of prescribing and the risks of potentially leaving the patient without medication if they had lost the medication. Pregabalin, tramadol, fluoxetine and propranolol should not be abruptly stopped due to the potential withdrawal effects and risk of myocardial infarction (commonly known as a heart attack) with abrupt withdrawal of propranolol.

16.11. The fourth area of concern is the long term prescribing of tramadol to Martine and how this drug may have impacted on both Martine and Adult B. There were three significant events in the months leading up to the incident which involved the taking of tramadol by one or both parties. Firstly, the incident on 6th August 2018 and following days, where both Martine and Adult B were admitted to hospital after experiencing seizures as a result of taking tramadol. Secondly, Martine took an overdose of tramadol, alcohol and cocaine on 6th December 2018. Thirdly, on the day of the murder, Adult B admitted to being

heavily under the influence of alcohol, tramadol and other illegal drugs in his interview with the Report Author.

16.12. The DHR Panel were so concerned by the potential effects of tramadol, they sought the advice of an expert on medicines in this issue as well. The below is a summary of information provided by the expert.[27]

16.13. The expert reported that, all four medications prescribed to Martine work on the Central Nervous System (CNS) i.e. brain and spinal cord, they are used to treat a wide range of neurological and psychiatric conditions as well as relieve pain, suppress nausea, and reduce fever. These drugs can either speed up or slow down the central nervous system through the transfer of electro-chemical messages in the brain.

16.14. Tramadol is a centrally acting opioid analgesic for the treatment of pain. This means the drug reduces your heart rate and blood pressure. Tolerance, mental and physical dependence may develop, especially after long-term use. When a patient no longer requires therapy with tramadol, it may be advisable to taper the dose gradually to prevent symptoms of withdrawal. There is potential for abuse and development of psychological dependence to tramadol, therefore the clinical need for continued treatment should be reviewed regularly. Treatment should be for short periods and under strict medical supervision. These tablets should be used with particular care in patients with a history of alcohol and drug abuse. Martine was prescribed tramadol for in excess of 17 years. Although she tried to mask her alcohol and drug dependency from professionals, this is an area of concern for the panel and will form the basis of a recommendation.

16.15. With regards to Adult B taking a combination of drugs and alcohol, the expert was asked to comment on the effects of combining prescription drugs with alcohol and cocaine. The expert reported that both tramadol and pregabalin can interact with alcohol and can have a depressant effect, which might affect the ability to perform skilled tasks. Cocaine is a stimulant whilst pregabalin and tramadol are depressants, the two types of drug send contradicting messages to the body; as a result, the body's function is greatly impaired. Cocaine will mask the effect of CNS depressant which may lead a person taking more and put them at risk of overdose.

[27] Source -Report from the Head of Medicines for Castle Point, Rochford and Southend CCG – dated 14/02/20.

Addressing the terms of reference

Term One

"To examine whether there were signs or behaviours exhibited by either the victim or perpetrator in their contact with services which could have indicated the level of risk?"

16.16. As a result of the DHR Review, the panel have concluded there were signs and behaviours exhibited by both Martine and Adult B in their contact with services which could have indicated the level of risk. These can be summarised as follows:

- Martine and Adult B were admitted to hospital between the 6th and 8th August 2018 with simultaneous seizures. It was clear from information provided by one of both of them that alcohol and drugs were a factor.
- There is mention in the notes following presentation at hospital on 6th August 2018 that rat poison may possibly have been taken by Martine. The reason given for it being in the property was because of an infestation of mice – this may have given some indication of poor living conditions.
- Adult B admitted to taking tramadol, (not prescribed to him), and had a history of cannabis (marijuana) abuse, both of which can have adverse effects on individuals especially when combined with alcohol.
- Martine took an overdose on 6th December 2018 following an argument with Adult B which caused him to tell her, he was leaving. Martine admitted to taking a cocktail of alcohol and prescription and illegal drugs.
- Adult A tried to cancel the ambulance, when called by Martine, to the report of her overdose on 6th December. This could be an indicator of controlling behaviour.

  Adult B was allowed to be present when medical practitioners were treating Martine following her overdose and during her consultation with practitioners from the Mental Health Team the following day. This could be an indicator of controlling behaviour.
- Martine during her assessment with the RAID team disclosed she was in debt and would seek advice from the Citizens Advice Bureau on debt management.
- Adult B was present at Martine's GP appointment on 10th December 2018 following her overdose. This could be an indicator of control.
- Martine disclosed to her GP during a consultation on 11th January 2019 that Adult B assisted her with her medication intake – this may have been an indicator of his control.

- Martine had a history of suicide attempts linked to her personal life. There is a link between mental health problems and domestic abuse. Mental health problems are a common consequence of domestic abuse and can render someone more vulnerable to abuse.
- The reports of loss of prescriptions shortly after taking an overdose. This could be an indicator of control if influenced by Adult B.
- A hidden risk, not known to professionals, was the fact Adult B kept an illegal firearm in the home which he admitted belonged to him. This is an indicator of control and intimidation.

16.17. It is worthy of note, however, and must be taken into account, that whenever Martine spoke to practitioners about Adult B, she did so in favourable terms and gave the impression he was her carer and looked after her. Martine said she took an overdose because she was distressed at the prospect that her relationship with Adult B was over. Professionals felt she seemed more positive, after their reconciliation.

Term Two

"Agencies reporting involvement with the victim and/or the perpetrator to assess whether the services provided offered appropriate interventions, risk assessments, care plans and resources. Assessment should include analysis of any organisational and/or frontline practice level factors which impacted upon service delivery".

16.18. As a result of the DHR process, there have been factors identified by participating agencies which are in need of improvement.

16.19. The professionals within health, acknowledged the long term prescribing of powerful opioids to Martine was inappropriate because of the effects these types of drugs can have on an individual's ability to function. Although the GP practice conducted frequent medical reviews with Martine, this aspect appears not to have been considered. This is especially relevant in this case because the review has revealed that Adult B also took Martine's prescription drugs as well as other substances and his level of intoxication and stupefaction may have been a factor on the day of the murder. Additionally, Martine, did not fully disclose to professionals her level of dependency on alcohol and other substances.

16.20. The professionals within health also acknowledged there were missed opportunities during Martine's consultations with them to exercise more professional curiosity about her personal circumstances and

relationship with Adult B. This included presentation at A&E with Martine and Adult B presenting with simultaneous seizures in August 2018; Martine's overdose and disclosure of a domestic argument on 6th December 2018; Adult B's acknowledgement he found it difficult to cope with the effects of Martine's EUPD and the frequent reports of lost medication or requests for increased dosages following her overdose.

16.21. The review has revealed there was a lack of recognition of the link between substance misuse, mental health and domestic abuse by professionals within Health. There is a significant amount of research which has been done which demonstrates the complex relationship between them. In May 2019, Safelives produced a spotlight report[28] which revealed some key facts which are relevant to this case. For example, people suffering with mental ill-health are more likely to have problems with drug and alcohol abuse; they are more likely to suffer financial constraints; are more likely to attempt suicide and more likely to present to their GP's and A&E with mental health issues with undisclosed domestic abuse being the underlying cause. In addition, it has been recognised that "There is a strong link between domestic violence and substance abuse, which has been studied and ascertained time and time again. A number of studies have concluded that the majority of domestic abusers have some sort of addiction issue, or reliance on substances"[29].

Term Three

"What learning if any is there to be identified in the management of either party. Is there any good or poor practice relating to this case that the Review should learn from? Each agency is asked to examine best practice in their specialist area and determine whether there are any changes to systems or ways of operating that can reduce the risk of a similar fatal incident taking place in future?"

16.22. There is some significant learning to come out of this review for those agencies involved. In many respects this has been a difficult review to conduct because so little information was known about Martine's relationship with Adult B. As is often the case, it is only when a review is conducted and all the information from each agency is considered as a whole does a clearer picture emerge.

[28] Safe Lives – Spotlight Report Safe and Well: Mental Health and Domestic Abuse May 2019
[29] Ocean Recovery Centre.Com – Links between Substance Abuse and Domestic Abuse – Posted 18th October 2019

Good Practice

16.23. With regards to agencies interaction with Martine, there is some good practice which must be acknowledged. She was supported by her GP practice, with whom she interacted regularly. She was referred to mental health services when in crisis and received long term support from EPUT. The information sharing between those organisations was very good and every time there was a significant event in Martine's presentations, the information was shared in a timely and appropriate way. She was appropriately referred to the RAID team following her overdose on 6th December and both her and Adult B were given support and follow up contact with the agencies.

16.24. Within SUFHT there is a Safeguarding Service that attends the A&E department daily, Monday to Friday. Referrals can be received electronically or by phone. Further information is available to staff on the Trust intranet system. The Emergency Department has a Safeguarding and Domestic abuse Lead who also provides additional training within the department, including indicators of domestic abuse, a Domestic abuse toolkit is also available to staff on Staffnet for further guidance. This should be seen as good practice.

Changes to existing practice to change outcomes for service users.

16.25. The circumstances of Martine's homicide have impacted significantly on those professionals involved and a significant amount of effort is already underway in trying to address some of the issues identified as a result of the review which are detail below.

16.26. The Head of Medicines Management for Southend CCG and Castlepoint and Rochford CCG has spent a considerable amount of time raising the agenda across the three CCG's around medication that may cause dependency. She has presented at Senior/Executive committees within the CCG's as well as to other colleagues. Both CCG's have agreed this is a priority area that needs closer attention and now have an executive Director who has volunteered to be the accountable lead.

16.27. There is a programme of work planned within the CCG on this issue which will include[30].

[30] This programme of work is already on-going, agencies are responsible for implementing their recommendations along with the CSP and will provide updates to the SETDA Team who are responsible for monitoring and updating action plans with updates provided to the SET DA Strategic Development Group.

- The production of a Standard Operating Procedure (SOP) for Control Drug (CD) monitoring for use within the CCG's.
- The regular monitoring of prescribed controlled drugs and production of quarterly reports detailing issues identified and actions taken. The reports will be disseminated to senior committees within the CCG's
- To conduct a practice level review of all Controlled drugs prescribing for outlying practices in both CCGs identified within the quarterly reports to include- over /unusual pattern in prescribing and non-formulary prescribing).
- Individualised practice level Controlled drug reports identifying areas for improvement to be presented to prescribing leads at each outlying practice and an agreed action plan and timescale to tackle variation in prescribing.
- Where practices have demonstrated significant reduction in CD prescribing, there will be direct liaison to ascertain and share learning.
- A Communication campaign is being planned, similar to "opioid aware", to educate the population and encourage the public to be proactive too.
- The Head of medicines and their team will be working with practices to start a review of high-risk patients (High dose opioids and combination or benzodiazepine and gabapentiniods).

Change in practice across the Queensway surgery and CCG

16.28. The lead nurse for safeguarding is in the process of developing a number of initiatives to improve the provision of services across the CCG. For example, as a direct consequence of Martine's homicide, she has secured funding from the 'Better Start – Southend' programme and has secured funding for an in-house IDVA to be available across six wards within the area including the GP practice. This is based on the 'Identification and Referral to Improve Safety' (IRIS) programme and has many links to it. The IRIS programme is a training and support programme to improve the response to domestic violence and abuse in general practice. At this stage the proposal is being processed to meet the Better Start Governance, guidelines, and management to ensure compliance for Audit.

16.29. The Lead nurse for safeguarding has conducted/facilitated high levels of training within the practice around the subject of domestic abuse and holds frequent lunch and learn sessions. She has included the learning to come out of this review to enhance the training.

16.30. In addition, there have been a number of teaching sessions regarding the care and well-being of vulnerable adults both at the surgery and across the CCG. GP Level 3 training has to meet the threshold of the NHS Intercollegiate document and must satisfy the CQC inspection team that practitioners are compliant and have the appropriate skills to perform their role. This training incorporates domestic abuse and its many elements, drug and alcohol abuse and mental health alongside and covers the subject of professional curiosity. There is a lead GP at Queensway surgery who is responsible for safeguarding and is the lead link with Southend Hospital. He oversees the training programme for all trainee GPs.

16.31. The practice has developed a 'Red Light" marker to be placed on records on vulnerable adults which will be available across the system 1 records and visible to health practitioners. This includes pharmacies and A&E. All practitioners can see the markers and have the ability to raise alerts quickly. The practice is in the process of reviewing all medications currently prescribed to patients across the practice with priority being given to those on opioid type medications and long-term use.

16.32. The DHR Chair has consulted with the lead safeguarding nurse outside of the panel process to discuss further improvements which need to be made and which will form the basis of recommendations. These include:

- Additional support and training to staff as set out in Adult Safeguarding guidelines[31],
- A revision of the structure of safeguarding meetings to ensure better oversight of the care of vulnerable adults, this will include a named GP or nurse being allocated to oversee vulnerable patient cases,
- To work with EPUT and agree an information sharing protocol which enables the CCG to access and view mental health records of patients at the surgery, sharing of relevant information to ensure care pathways are managed effectively to achieve best quality outcomes for the patient.

Changes in practice for SUFHT

16.33. The lead safeguarding officer for Southend A&E has submitted a business case for funding for the reintroduction of an IDVA within A&E.

[31] Royal College of Nursing - Roles and Competencies for Health Care Staff First edition: August 2018.

17.0 CONCLUSIONS/LESSONS TO BE LEARNT

17.1. This is a tragic case where Martine's life was taken in the most horrific circumstances at the hands of Adult B. Adult B pleaded guilty to her homicide and is currently serving life imprisonment with a recommendation, he will not be considered eligible for parole for 26 years.

17.2. Due to the fact Martine had been estranged from her family for many years prior to her murder, her voice is not represented as well as the Review Panel would have liked. Martine did have contact with professionals both during the period under review and historically. This was linked to her diagnosed mental health conditions and problems with her physical health. There was a recorded history of domestic abuse with previous partners, and a history of previous suicide attempts. In the last nine months of her life, she entered into a relationship with Adult B. There is little information known about the dynamics of the short relationship between Martine and Adult B which led to her homicide in January 2019.

17.3. With regards to Adult B, little is known about his life due to the fact he had little contact with professionals and his family, perhaps the people, who know him best, have chosen not to engage with either the police investigation or this review. Adult B did agree to meet with the review author but advised he was unable to provide a great deal of information about the last month he spent with Martine due to the effects of alcohol and drugs which seem to be a factor in this case.

17.4. The Review Panel considered four factors which may have contributed to what happened. The fact remains, the only person who knows what happened has stated he has no recollection of the events of that day.

1. Adult B's dependency on a combination of alcohol and legal and illegal drugs significantly affected his behaviour.
2. There appears to have been an escalation in the taking of illicit substances in the days preceding the murder which is supported by the frequent reports of lost prescriptions.
3. Adult B could not cope with Martine's grief over the loss of an ex-partner. The timing of the murder coincided with the upcoming second anniversary of his death.
4. Adult B did display signs of controlling and coercive behaviour towards Martine.

17.5. There were two significant incidents where professionals had contact with both Martine and Adult B which presented opportunities for professionals to gain an insight into their relationship. These were related to presentations at hospital in August 2018 where they both suffered with seizures thought to be linked to consumption of alcohol and drugs and Martine's overdose taken on 6th December 2018 following a domestic argument with Adult B. In addition, there were a number of follow-up medical consultations with the GP surgery following these incidents and this is where the panel have identified the learning which has arisen from this review.

Learning Point One - Understanding of coercive control

17.6. The DHR Panel considered the current training provision within the organisations which feature in this report around the subject of domestic abuse. All IMR authors recorded detail of training provision and it is clear that all agencies take this subject seriously and regular training is provided. The DHR Panel are concerned, however, that there may be a lack of understanding of the signs and symptoms associated with coercive control within the definition of domestic abuse.

17.7. The definition of domestic 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." Coercive and controlling behaviour is defined as "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. 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".

17.8. Certainly, in this case, there were signs that Martine, was subject of coercive controlling behaviour exhibited by Adult B. The Review Panel was concerned that practitioners did not pick up on the significance of some of the things they were aware of. This is despite the established evidence base in relation to health care that identifies the wide range of presenting problems or conditions that are associated with domestic abuse.

17.9. A summary produced by NICE identified the following indicators including associated with domestic abuse:

- symptoms of depression, anxiety, post-traumatic stress disorder, sleep disorders
- suicidal tendencies or self-harming
- alcohol or other substance use
- Intrusive 'other person' in consultations including partner or husband, parent, grandparent.

17.10. The above is not the definitive list outlined in the guidance, but the relevant ones which have been identified during the review, as impacting on Martine.

Learning Point Two – Lack of Professional Curiosity

17.11. This review has identified opportunities where professionals within the Queensway Centre, A&E, and EPUT could and should have picked up issues or gleaned information about the nature and relationship between Martine and Adult B. This is explained in detail within the analysis section of this report.

17.12. The review has identified a need for professionals to be reminded of guidance contained with NICE guidelines and the Southend, Essex and Thurrock Safeguarding guidelines. NICE Guideline 55 states "Professionals should maintain professional curiosity and questioning while building a good relationship" The SET Safeguarding Guidelines April 2019, states "Professional curiosity is the capacity and communication skill to explore and understand what is happening within an adult rather than making assumptions or accepting things at face value. Professional curiosity can require practitioners to think 'outside the box', beyond their usual professional role, and consider circumstances holistically. Curious professionals will spend time engaging with adults. They will ask questions (in an open way) and seek clarity if uncertain and will be open to the unexpected"

17.13. Staff within health including those at the Queensway Centre, A&E and EPUT all became aware that Martine's overdose of the 6th December 2018 was precipitated by a row with Adult B which resulted in him leaving her. This could be seen as a relevant question area for professionals to have explored further with her, especially when considered alongside the other factors detailed in this report relating to Martine's history of mental ill-health, her previous suicide attempts, and dependency on prescription drugs.

Learning Point Three – Safe Environment

17.14. Closely linked to the above is the importance of creating an environment to enable a patient to disclose abuse. At the time, Martine presented in crisis having taken an overdose on 6th December 2018, and during her subsequent assessment with practitioners from the mental health team, the following day, Adult B was allowed to be present. Whilst this could be perceived as Adult B being supportive of Martine in her time of need, it could also be seen as a controlling act which inhibited her ability to disclose abuse to professionals. This is particularly valid if taken together with the fact, that Adult B tried to cancel the ambulance that Martine had called reporting her overdose.

17.15. NICE Guidelines and Public Health regulations stress the importance of creating a safe environment to enable patients to disclose domestic abuse. As part of the IMR for SUFHT the author referred to local guidance on Professional Curiosity and NICE Guidelines for Domestic violence and abuse: multi-agency working - Public health guideline [PH50] Published February 2014 with particular reference to Recommendations 5 which states ' Create an environment for disclosing domestic violence and abuse" [32]. The review has identified that the environment could have been better considered to encourage disclosure.

Learning Point Four Tracking of prescriptions

17.16. The review has identified from entries on notes held within health (10th December 2018 and 7th January 2019) and from information provided by Adult B that Martine reported loss of prescriptions and was prescribed further medication without any real challenge. The reason given for this by Adult B was that the drugs were needed to feed their addictions. This could have been in the context of coercive and controlling behaviour by him.

17.17. The expert on medicines commissioned by the Review Panel was asked if they had any recommendation which need to be considered as a result of this case. The expert reported that all GP practices should be moving to electronic prescribing which has functionality for prescriptions to be tracked; this should be embedded as a routine check for all claims of lost prescriptions especially for vulnerable patients and drugs that can cause dependency/abuse. This forms the basis of a recommendation.

[32] National Centre for Clinical Excellence 2014 – Domestic Violence and Abuse (PH50)

Learning Point 5 - Long term prescription of opioids

17.18. The DHR Panel identified concerns over the long-term prescribing of powerful opioids to Martine, particularly tramadol. The side effects of these drugs can have a serious impact on a persons' ability to function particularly when taken in combination with other drugs and alcohol. Both Adult B and Martine had a dependency on legal and illegal drugs and alcohol.

17.19. The expert commissioned by the panel reported there had been a recent review in 2019 by Public Health England who had published a report on prescribed medicines entitled "Dependence and withdrawal of some prescribed medicines". That report has a number of recommendations contained within for health professionals linked to the dangers of long-term use of opioid drugs.

Learning Point Six – Knowledge linked to the domestic abuse, mental health and substance misuse.

17.20. The DHR Panel have identified, there was a lack of recognition by professionals of the dangers of the combination of mental health, substances misuse and domestic abuse. There is a strong body of evidence available to support the assertion that when these three factors combine, the risk of a person being harmed through domestic abuse or perpetrating an act of domestic abuse is significantly heightened. The panel believe improving awareness, early identification and responses through further training and education, could be considered beneficial for all professionals across the local CCGs.

Learning Point Seven – Disclosure of information between call takers and first responders (EEA)

17.21. The review has identified some key information taken by the EEA call takers on 6th December 2018 was not communicated to the first responders or A&E personnel. This related to the fact that Adult B tried to cancel the ambulance called by Martine following her overdose. Clinicians who engage with service users by phone must ensure that any concerns are raised with the attending crew. It is important that all practitioners communicate concerns so that correct decisions can be made in respect of subsequent referrals.

Learning Point Eight – Downgrading on domestic abuse incidents before attendance.

17.22. The review panel considers that the regrading of the incident by the police on the day of Martine's homicide from Priority 1 to 3 was premature given the nature of what was being reported by Martine (boyfriend being violent and abusive) coupled with the fact that Fore Control Room (FCR) Staff were then unable to make contact with her after she had ended the initial call.

18.0 RECOMMENDATIONS

18.1. This section of the Overview Report sets out the recommendations made by the DHR Panel:

Recommendation One

All agencies need to consider their internal arrangements for training provision around the subject of coercive control, the effects of trauma within an inter-personal relationship and the key changes being introduced within the forthcoming Domestic Abuse Bill/Act.

Recommendation Two

The SETDAB to deliver a campaign to raise awareness of all professionals concerning the importance of professional curiosity and issues which need to be explored, particularly when dealing with adults who suffer with mental ill-health, and substance or alcohol misuse as they may be factors which heighten the risk of domestic abuse.

Recommendation Three

The Southend University Foundation Hospital Trust Emergency Department to review its procedures to ensure environmental privacy is optimised to promote disclosure from patients, particularly those who are in crisis.

Recommendation Four

All GP practices across SET, should be moving to electronic prescribing which has functionality for prescriptions to be tracked; this should be embedded as a routine check for all claims of lost prescriptions especially for vulnerable patients and drugs that can cause dependency/abuse. (The CCG medicines management team can support the dissemination of this information to all practices).

Recommendation Five

NHS Southend CCG should support Queensway Surgery to develop a process to ensure that all staff at the practice have safeguarding competencies relevant to their roles and responsibilities in line with the requirement set out in the Adult Safeguarding: Roles and Competencies for Health Care Staff First edition: August 2018. Clinical supervision records would provide an excellent reference point for monitoring, audit, and quality.

Recommendation Six

Queensway Surgery should ensure that all staff are aware of the function and application of the S1 vulnerable adults' icon and undertake teaching / refresher sessions and an audit to provide assurance that it is being effectively used.

Recommendation Seven

Queensway Surgery should review and revise the structure and function of the multi-disciplinary and safeguarding meetings so that the care of vulnerable adults has appropriate oversight by the team. This should include the allocation of a GP/Nurse to act as lead professional for the patient on behalf of the Practice.

Recommendation Eight

Queensway Surgery should continue to explore with EPUT the sharing of relevant information about patients who are under the care of EPUT clinicians to ensure care pathways are managed effectively to achieve best quality outcomes for the patient.

Recommendation Nine

The Clinical commissioning groups across SET to raise awareness of the 2019 Public Health England report on Prescribed medicines "Dependence and withdrawal of some prescribed medicines" and the recommendations contained within. To also ensure a process is put in place to obtain regular progress reports from the Director overseeing the CCG programme of work associated with the monitoring and prescribing of medications as defined under the report.

Recommendation Ten

All Health and Social Care Professionals to disseminate the learning from this review, to raise awareness of practitioners of the complexities surrounding mental health and substance/alcohol abuse. Practitioners need to be aware that while they do not cause the abusive behaviour, they may be a contributory factor. This aspect should be considered in any routine assessment process when one of more of these factors are present.

Recommendation Eleven

The East of England Ambulance Service should raise the awareness of all telephone clinicians that any concerns raised during a 999 call, should be highlighted to the attending crew. (In this case there was the possibility that

the patient was being coerced by the partner not to have an ambulance attend the scene following a report of an overdose.)

Recommendation Twelve

Essex Police should reinforce to relevant staff within the Force Control Room, the need to fully record within the THRIVE assessment their rationale for downgrading STORM Incident Response Priorities. In particular, the assessment should fully reflect the change in circumstances leading to the Priority regrading.

Recommendation Thirteen

In cases where a 999-call reporting domestic abuse to the police is terminated prematurely, incidents should not be downgraded until contact has been re-established with the caller. This should be reflected in Essex Police Policy Guidelines.