BIRMINGHAM COMMUNITY
SAFETY PARTNERSHIP
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Domestic Homicide Review

Executive Summary of the report into the death of a woman

DHR2011/12 - 02

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Presented to Birmingham Community Safety Partnership on
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INTRODUCTION

The purpose of this Domestic Homicide Review (DHR) is to:

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

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

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

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

A DHR is not an inquiry into how a victim dies or into who is culpable as those matters are for Coroners and criminal courts to determine. DHRs are not specifically part of any disciplinary enquiry or process. Where information emerges during the course of a DHR which indicates that disciplinary action should be initiated then the relevant agency disciplinary procedures should be undertaken separately to the DHR process.

In production of this report agencies have collated sensitive and personal information under conditions of strict confidentiality. The Birmingham Community Safety Partnership (BCSP) has balanced the need to maintain the privacy of the family with the need for agencies to learn lessons relating to practice identified by the case and has authorised the publication of sufficient information to enable this to take place.

A decision to undertake a Domestic Homicide Review was made on the 30 January 2012. The BSCP determined that agencies would secure and review their files from 1 October 2009 until the date of the victim's death. Agencies attended an initial panel meeting on 19 March 2012 and were required to compile an Individual Management Review (IMR) to provide an independent, open and critical analysis of individual and organisational practice. The IMRs identify lessons learnt by the individual agencies, highlight any good practice and include recommendations for single agencies to improve practice.

Terms of Reference

In addition to the generic terms of reference contained within the *Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Home Office 2011),* the following **specific issues were to be addressed by all agencies**:

- Whether domestic violence was known to be a feature of the victim or perpetrator's life?
- How this affected the risk management of the victim or perpetrator.
- How this affected the care or treatment of the victim or perpetrator.

- If not known, whether agencies have policies and processes of routine and direct questioning or screening for domestic violence, and if so, how these affected practice.

The following agencies addressed additional specific issues:

West Midlands Police

- Whether the perpetrator had any known previous violent history and was subject to any offender management processes
- Evaluation of the outcome of the Police investigation into allegations made by the perpetrator that he had been poisoned in 2009
- Whether police intervention into the incidents of identified vulnerability involving the perpetrator resulted in appropriate inter-agency referral.

Birmingham and Solihull Mental Health Foundation Trust

- Whether the discharge for treatment and referral to the G.P. in June 2010 adequately took account of potential risks to the victim and other family members.
- Whether psychiatric assessment and intervention in December 2011 was appropriate and included consideration of the potential risk to the victim and others.

The following agencies participated in this review:

- Aquarius
- Birmingham City Council Adult Social Care
- Birmingham City Council Landlord Services
- Birmingham Community Healthcare NHS Trust
- Birmingham and Solihull Mental Health Foundation Trust
- Birmingham & Solihull NHS Cluster (GPs) - now known as Clinical Commissioning Group and NHS Area Team
- Freshwinds
- Heart of England NHS Foundation Trust
- West Midlands Police

SYNOPSIS

On 22 December 2011, West Midlands Police were contacted by Birmingham Market Police who reported that the perpetrator had approached them and claimed that he had killed his wife. Enquiries were commenced and as a result his home address was searched and the body of the victim was found. She had been reported as missing by her daughter 18 hours previously. The perpetrator was subsequently charged with murder, convicted and on 20 March 2013 was sentenced to life imprisonment. There was a significant delay in the criminal proceedings whilst the mental health of the perpetrator was assessed. He was diagnosed as suffering from a personality disorder but was deemed fit to stand trial.

The perpetrator and the victim were not married and had never lived together. They had known each other since the 1960s when the victim and her partner mixed in the same social circles as

the perpetrator. They met by chance after the death of the victim's partner in 2005 when a relationship developed between them. The nature of the relationship is unclear and the victim's family believe it was a friendship rather than an intimate relationship. However, early in the criminal investigation indications were that theirs was a relationship which met the criteria for a domestic homicide review to be undertaken.

The victim and the perpetrator were frequent visitors to their respective GPs. The victim suffered from a chronic respiratory disease and from depression. The perpetrator suffered with his mental health over a long period of time and often presented with anxieties over his physical health. Problematic alcohol use was a feature for both the victim and the perpetrator and both sought counselling and support in this respect. The victim did not pursue her referral and her family have stated that she managed to overcome her problems with alcohol. The perpetrator did complete a course of counselling but despite seeking help at a later date did not pursue his referral. It is believed that the perpetrator also used illicit drugs.

Both the victim and the perpetrator lived in poor housing in socially deprived areas. The victim was in debt and sought financial help with particular concern about her fuel bills as she was known not to switch on her heating which was detrimental to her health.

From agency records little was known about the victim and during this review no agency or professional were aware of any relationship between the victim and the perpetrator. The victim never stated that she was in a relationship and never reported any incidents between them. The only incident reported was when the perpetrator claimed that his 'girlfriend' was poisoning him but her identity was never established. The police did not pursue the matter after it was established that he had been subject of a referral for secondary mental health services and tests in respect of him being poisoned proved negative. However he resisted engaging with mental health professionals and eventually was discharged back into the care of his GP.

It is known that the victim had been subjected to domestic violence by her deceased partner over a number of years. She was quite vulnerable emotionally and physically and the perpetrator seemed to have identified this and was quite controlling of her. The victim indicated to her family that she wanted to end their relationship and it is believed that it was her intention to do so when she visited him on the day that she was murdered.

FAMILY AND ASSOCIATES ENGAGEMENT

The adult daughter of the victim contributed to this DHR providing information which greatly assisted the findings, learnings and conclusion.

LEARNING

Key Issues:

- **Professional Curiosity/Judgement**

No agency had any record of the victim and the perpetrator being in a relationship despite the perpetrator referring to his 'girlfriend'. There lacked any curiosity about her identity and any potential risk posed to her. The focus remained upon the perpetrator without any consideration or risk assessment of whether concerns about his mental health impacted upon the safety of others.

- **Mental Health**

The victim suffered from a long standing depression which was controlled by medication but there is no evidence that the root cause of her condition was ever explored.

The perpetrator had long standing mental ill health issues and showed a resistance to engage with mental health services and indeed a decision to discharge him from the mental health service was influenced by his reluctance to engage.

- **Domestic Abuse**

At no time was either party asked by professionals whether they were victims of domestic abuse apart from the allegations by the perpetrator that he was being poisoned by his 'girlfriend'. The view of family members is that the perpetrator was controlling and possessive of the victim and resistant to her attempts to end their association. Neither of the GP surgeries had domestic abuse policies in place; staff were not aware of protocols agreed with other agencies and there was no questioning of the victim when she reported having personal problems that she indicated she could not talk about.

Lessons Learnt

- Generally good information sharing between agencies in respect of the perpetrator's mental health and the financial difficulties encountered by the victim.
- Lack of professional curiosity about the identity of the perpetrator's 'girlfriend'.
- Lack of a full police investigation regarding the allegation of being poisoned and a reliance on mental health service intervention.
- Lack of policy and procedure in respect of domestic abuse in GP practices.
- Insufficient planning and agreement of future action when the perpetrator failed to engage with the secondary mental health service.
- Failure to assess any risk posed by the perpetrator to others, particularly to anyone who he was in a close relationship with.

GOOD PRACTICE

No examples of good practice over and above expected levels of service were identified during this Review.

CONCLUSION

It has been established that no professional was aware of a relationship between the victim and the perpetrator. There was however a failure by the police to enquire about the identity of the 'girlfriend' and by the GP to seek further information in relation to personal problems mentioned by the victim.

Whilst no incidences classified as 'domestic violence/abuse' were reported, had professional curiosity been exercised it is possible that the nature of the relationship between the victim and the perpetrator would have been ascertained which may have resulted in interventions by agencies. However with this lack of awareness, it is concluded that in this case the death of the victim could not have been predicted or prevented.

RECOMMENDATIONS

There are no overarching recommendations from this overview report as it is felt that improvements to service delivery and the single agency recommendations which have resulted from IMRs and from one information report are sufficient to address the issues raised during this review. These are as follows:

Recommendations made by Birmingham and Solihull Mental Health Trust

- Remind staff that they should clearly record information about children, partners and significant others in the service users clinical record, including any potential risks identified.

- Whenever a service user is lost to follow up relevant partner organisations who will be involved in agreeing any future action.

- All clinical staff should have access to the Department of Health Routine Enquiry Training into Abuse and Neglect

Recommendations made by Birmingham South Central and Cross City Clinical Commissioning Group

- The findings of the DHR are circulated to all general practices

- All General Practices are informed in writing of the need to have clear policy statements and procedures in place with respect to domestic abuse and safeguarding adults at risk

- Royal College of General Practitioner Guidelines are circulated to all general practices with a recommendation that a designated person is identified and a domestic abuse care pathway is established, as per the guidance

- All staff working in general practices receive training in recognising and responding to domestic abuse which is commensurate to their role.

Recommendations made by Heart of England NHS Foundation Trust

- All medical & nursing staff to be reminded of good practice & Trust policy in relation to record keeping and documentation

DOMESTIC HOMICIDE REVIEW PANEL FOR BDHR2011/12-02

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