A domestic homicide review into the deaths of Victoria and Andrew Hudson

Executive Summary

A report for
West Berkshire Safer Communities Partnership

December 2009

Contents

1. Introduction

1.1 On the Monday 20th October 2008 Victoria Hudson was found unconscious at her home at 32 Buttercup Drive, Thatcham and death was certified at the scene by a Paramedic. On Tuesday 21st October the body of Andrew Hudson was found in his car at Catmore Road, West Ilsley.

1.2 This report reflects the output from a Domestic Homicide Review set up by the West Berkshire Safer Communities Partnership under the terms of reference shown in chapter 2. The report considers the time period of a year prior to the homicide in October 2008 and considers the involvement and actions of agencies and professionals prior to and during the incident. The findings are outlined and recommendations made, alongside the reflections of family, friends and colleagues, on improvements to the services for victims of domestic violence.

1.3 In accordance with the "Guidance for Domestic Homicide Reviews under the Domestic Violence Crime and Victims Act 2004" three agencies have been asked to provide an Internal Management Review (IMR) of their involvement with the family or individuals. The agencies providing information are West Berkshire Council, NHS Berkshire West and Thames Valley Police. In addition, information has been provided by work colleagues of Victoria Hudson, Person C, friend of Andrew and new partner of Victoria and by Person E.

1.4 Again in line with the guidance, the opportunity to contribute to the review was offered to a wider group of family and there was an opportunity for others to be informed through family members to contact the Chair of the review. Similarly, offers were made to Andrew's employer and the Territorial Army (TA), who chose not to respond to the invitation, where Andrew had spent time training. There is some considerable interest from the family in the outcome of the review and the inquest, which is due to take place in February 2010.

1.5 The conduct of the review was complicated by the lack of access to personal contact information by the review other than through the Community Safety Partnership, the West Berkshire Local Police Area Commander and the Thames Valley Police Family Liaison Team who continue to provide invaluable support to the families of both Victoria & Andrew. Future guidance needs to provide the review process with the right to access personal information to allow the review to proceed, especially where individuals are not inclined to offer or press for their involvement.

1.6 There is a tension between the current guidance provided by the Home Office in 2004 and the reality of conducting such a review within the limited resources of a Safer Communities Partnership environment. There is no formal authority through which to act or require anything other than volunteers to come forward. Data Protection continues to provide a barrier and the reliance is on agencies to comply with requests for assistance. Given the lack of response from the TA, it may be considered that the assertion of pressure, through additional guidance from the Home Office, is required to ensure that both the TA and if appropriate the regular forces to respond to similar cases. It is fortunate that in West Berkshire the principles of partnership and professional trust and confidence mean that the review has been produced.

1.7 Further guidance would be welcomed from the Home Office outlining the link between the necessary internal management processes triggered by the IMR and the timescales for producing the DVHR. This means that the initial timescales for the production of the DVHR, inline with the guidance are necessarily extended. The impact on the Coroners inquest process should also be considered, as there is a lack of clarity about whether an inquest should take place before or after the DVHR reports.

1.8 Thanks are due to all of those who volunteered to participate and offer their views, reflections and details of the circumstances as they were aware of them. It is clear from the TVP IMR that there are other people who have provided information as part of the Police investigation but this was not directly available to the review as people did not contact the Chair to offer their views. The TVP IMR provides a clear record of events that is verified by the views and reports from friends and family who participated.

2. Terms of Reference

A domestic homicide review of the deaths of Victoria & Andrew Hudson

Terms of reference

January 2009

West Berkshire Safer Communities Partnership – Terms of reference

This domestic homicide review is commissioned by the West Berkshire Safer Communities Partnership (WBSCP) in response to the deaths of Victoria & Andrew Hudson in October 2008.

This internal domestic homicide review was commissioned because there are school age children involved in this case and therefore there had been contact with the local authority and there had also been Primary Health Care contacts with the family. The review will follow the draft guidance issued by the Home Office in 2006 for domestic homicide reviews under the Domestic Violence, Crime and Victims Act 2004.

The WBSCP appointed Jim Holah, Divisional Director at Sovereign Housing Association as Chair of the review team at the Strategy Group meeting held on 10 December 2008. Jim is not employed by any of the statutory agencies involved in the review as identified in section 9 of the Act, is a member of the Safer Communities Partnership Strategy Group.

Purpose of the review

The purpose of the review is to:

- Establish the facts that led to the incident in October 2008 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family
- Identify what those lessons are, how they will be acted upon and what is expected to change as a result
- Establish whether the agencies or inter agency responses were appropriate leading up to and at the time of the incident in October 2008
- Establish whether agencies have appropriate policy and procedures to respond to domestic abuse and to recommend any changes as a result of the review process

Domestic homicide reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

Scope of the review

The review will

- Seek to establish whether the events of October 2008 could have been predicted or prevented.

- Consider the period of one calendar year prior to the events, subject to any information emerging that prompts a review of any earlier incidents or events that are relevant.

- Request Internal Management Reviews by each of the agencies defined in Section 9 of the Act, and invite responses from any other relevant agencies or individuals identified through the process of the review.

- Seek the involvement of the family, employers, neighbours & friends to provide a robust analysis of the events.

- Take account of the coroners inquest in terms of timing and contact with the family

- Produce a report which summarises the chronology of the events, including the actions of involved agencies, analyses and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature

- Aim to produce the report by the end of May 2009, subject to responding sensitively to the concerns of the family, particularly in relation to the inquest process, the internal management reviews being completed and the potential for identifying matters which may require further review.

Family involvement

The review will seek to involve the family of both the victim and the perpetrator in the review process, taking account of who the family wish to have involved as lead members and to identify other people they think relevant to the review process.

We will seek to agree a communication strategy that keeps the families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this.

We will identify the timescale and process of the coroners inquest and ensure that the family are able to respond to this review and the inquest avoiding duplication of effort and without undue pressure.

Legal advice and costs

Each statutory agency will be expected and reminded to inform their legal departments that the review is taking place. The costs of their legal advice and involvement of their legal teams is at their discretion.

There may be a requirement to access independent legal advice on the part of the review team, and the team will seek funding of this advice from the Safer Communities Partnership statutory partners and agree from which source this advice will be sought.

At this stage it is not anticipated that the review will require additional resources or funding for their time to undertake this review. Should the scope of the review extend beyond the anticipated internal review, the review team will raise this through the Safer Communities Partnership for further guidance.

Expert witnesses and advisors

It is intended to consider consulting with the following agencies and individuals to provide a view of the findings and recommendations arising from the report.

- Thames Valley Partnership Domestic Abuse Lead Officer, Julia Worms
- Domestic Abuse Co-ordinator for West Berkshire, Jo McIntyre

Other appropriate agencies and people may be identified through the course of the review.

Media and communication

The management of all media and communication matters will be through a joint team drawn from the three statutory partners involved ie Thames Valley Police, Berkshire West Primary Care Trust and West Berkshire Council.

There will be no presumption to inform the public via the media that a review is being held in order to protect the family from any unwanted media attention. However, a reactive press statement regarding the review will be developed to respond to any enquiries to explain the basis for the review, why and who

commissioned the review, the basic methodology and that the review is working closely with the family throughout the process.

An executive summary of the review will be published on the West Berkshire Partnership website, with an appropriate press statement available to respond to any enquiries. The recommendations of the review will be distributed through the partnership website, the Domestic Abuse Forum and applied to any other learning opportunities with partner agencies involved with responding to domestic abuse.

All written communication from the review team will be sent under the Safer Communities Partnership logo, using business addresses for the review team members.

3. Conduct of the review

3.1 This review has been conducted confidentially and with the exception of Victoria & Andrew Hudson, a coding protocol has used to identify those contributing to the review. Where appropriate, job titles or call signs have been used to refer to staff and officers

3.2 The review comprised:

- Interviews with a family member by phone, personal interviews with Person A and Sister, a personal interview with a friend of Victoria & Andrew and a meeting with colleagues of Victoria.
- Internal Management reviews were requested from three agencies, Thames Valley Police, the NHS West Berkshire & West Berkshire Council. These IMR's were extremely thorough and there has been no requirement to further interview staff as a result of these reviews.
- Listening to a recording of the call from Victoria to TVP on the 14th October 2008
- Expert opinion taken from Domestic Abuse specialists in West Berkshire

3.3 This review was originally intended for publication by May 2009 but has been delayed in its production because of the time taken to produce the internal management review carried out by Thames Valley Police, which were outside of the initial terms of reference. This is not a criticism as the resulting IMR is exceptionally full and clear. Arising from the IMR were a number of issues regarding the relative priority of the Domestic Violence Homicide review process alongside both Police & Coroner's Inquest procedures.

3.4 Where appropriate, extracts from the IMR's have been used to illustrate clearly either the process or failure of systems or procedures to respond to the situation.

3.5 The document was drafted after a thorough analysis of the documentary evidence provided through the IMR's and from records of notes taken at the time. Effectively, this has been carried out by the Chair of the review, with a small group of officers available to assist in the preparation of the review and in considering the draft document prior to presentation to the West Berkshire Safer Communities Partnership.

3.6 There could usefully be further direction and guidance from Government on both the conduct of these reviews, their relationship to existing procedures and the way in which the speed of the review conflicts with the grief and concerns on the family members closely linked to the core events. The DVHR process, conducted in parallel with the Police and Coroner inquiries, causes confusion and pressure that could be avoided if they were streamlined and co-ordinated.

4. Executive summary

4.1 Victoria and Andrew Hudson were married in 1994 and had two children, born in 1997 and 2002. Andrew also had a son from a former marriage. In the early years of the marriage there is no evidence from family or friends to suggest that this was anything other than a generally happy marriage. There is however evidence from both Person A & Person B that Andrew and Victoria had some tensions in their relationship and that Andrew had been uncommunicative, controlling and manipulative in his relationships.

4.2 Victoria had confided in a friend Person I that she'd had some difficult years with Andrew, remarking that he spent a lot of time either playing computer games at home or through his involvement with the Territorial Army, away from home on exercises and training.

4.3 It is reported that Victoria confided in her friend and subsequent new partner Person C that she had tried to talk to Andrew about their relationship and marriage but that *"this was not his approach, as he was a very quiet person and did not communicate in this way with his wife".* It is also reported that Victoria suggested marriage guidance but that the suggestion was not supported by Andrew.

4.4 The TVP IMR, through interviews with friends outlines the following incidents in May 2008. "*Person F was an old school friend of Andrew's, another mutual school friend was Person C. In May 2008 Person F had a barbeque at his home to celebrate his birthday. Person C describes how he and Victoria got chatting during the course of the barbeque and discovered that they were both having personal problems. He says they got on well sharing their problems. The following day they started being in regular phone contact. Victoria explained that her marriage was in difficulties and that Andrew took very little notice of her. She said she'd tried to talk to him about it, but he wouldn't discuss the problems with her.*

4.5 In discussions with Person E, it was stated that she *"knew of no problems before the incident*" occurred in October 2008. She *"didn't know of any need for help"* although she was aware that Andrew was off work with depression. She *"knew nothing* (of the marriage difficulties) *until Victoria moved out"* of the matrimonial home

4.6 Person C has made it clear that from his perspective, that, with the exception of a friend that Victoria and he stayed with in Cornwall in the summer of 2008, that no-one else knew of their relationship.

Person C reports that at this time Victoria was attempting to discuss the marital problems with Andrew but without success.

4.7 The TVP IMR also reports that: *In July 2008 Andrew and Victoria went away on a camping holiday with friends of theirs. The friends were Person G and his wife, Person C and Person F. A few days after this weekend, Andrew rang Person G to tell him his marriage was over, and he suspected Victoria was having a relationship with Person C, although when challenged, Victoria had denied this.*

4.8 This appears to be the first point at which Andrew suspects that there is a relationship between Victoria and Person C. In the summer of 2008, Andrew is reported to say to his Mother in Law, Person A *"I've messed it up"* in relation to his marriage.

4.9 During August, Andrew accessed the records of a mobile phone owned by Victoria, identifying 500 + texts and exchanges between Victoria and person C.

4.10 The relationship between Andrew & Victoria continued to deteriorate during the summer of 2008, with Andrew moving out to stay with a friend in Swindon, while Victoria's relationship with Person C developed, with daily contact by phone and text a normal occurrence.

4.11 Andrew contacted Person A in September 2008, indicating that he was at The Samaritans and on meeting Andrew at her home, called Victoria home from work and then arranged for Andrew to visit his GP, who signed him off sick for two weeks. Andrew stayed with Person A for two weeks, was on medication and was assessed for suicide risk.

4.12 During attendance at a Territorial Army exercise, Victoria by agreement with Andrew moved from the family home to a property in Buttercup Place. Friends and family were aware of the situation and indicated that Victoria was happier and planning for the future.

4.13 Andrew was continuing to see his children and contacting Victoria, who reported to family that she found the calls intimidating and harassing.

4.14 On the 14th October Victoria contacted Thames Valley Police for advice, expressing her concern about Andrew, that he has threatened her new partner and may possibly harm him and himself.

4.15 The TVP Operator establishes that there is no direct or immediate threat to Victoria and concludes that Victoria's main concern is for Andrews welfare. She then goes on to confirm that without a specific threat or incident, there is little TVP can do, and that intervention can even make the situation worse.

4.16 The Operator establishes more information and provides general advice to Victoria, who concludes *"I don't want not to have done anything……but there's nothing I can do really apart from persuade him to go to somebody else (for help)"*

4.17 It is significant that no record of this call was made on any TVP system, either the Command & Control system or the Contact Management System. This did not comply with the National Standard for Incident Reporting and the Standard Operating Procedure for Domestic Incidents.

4.18 The lack of a record did not offer the potential reference of Victoria's situation to specialist advisors who may have been able to provide support or guidance through local agencies such as Berkshire Womens Aid or the West Berkshire Domestic Abuse Unit.

4.19 Expert witnesses have reviewed the call and the outcomes and identified where additional questioning, a record on the system and a referral to relevant agencies may have provided support and help to Victoria.

4.20 TVP have, through their internal review, already identified learning outcomes and have initiated training courses for Control Room Operators to highlight the potential for Domestic Abuse cases to be identified and what services are available to assist, other than direct intervention by the Police.

4.21 Between the 14th & 20th October, Andrew indicated to Victoria that he had a plan to carry out if he was sure that Victoria was seeing Person C, and that *"it'll be too late for the Police when I do what I'm going to do".*

4.22 Andrew also had a conversation with Person C, warning him from seeing Victoria, with Person C saying *"If I want to see your wife I will".* The call ended with Andrew saying "*It ain't F…… over"*

4.23 Andrews parents visit his home to support their Son, knowing that he was signed off sick from work and that the marriage was in difficulties.

4.24 Over the weekend of the 18th & 19th October 2008, Andrew took the children to visit a friend, telling him that *"if Person C and Victoria ever got together, he would kill him and then kill himself.*

4.25 Over that weekend, Person C delivered by arrangement some furniture to Victoria's new home, leaving on Sunday before Andrew returned the children home. Andrew, seeing the furniture realised that Person C had been at the home and according to a report *"went mad", pointing at Victoria and said "That's it".*

4.26 On the 20th October, Andrew left for work with his Son, stayed for a short time and left at about 9.30am.

4.27 Victoria called in to see her Mother at about 1.30pm reportedly *"noticeably happier than she had been in a long time".*

4.28 Andrew texted a friend at 2.43pm saying *"I'm sorry mate, but I can't go on. Person C came down on Sunday, that's why Vicky wanted me to take the kids. I'm gonna miss u all I'm sorry but the pain is too deep I cant get rid of it I love you all but life is not worth it now and there is no way I accept Person C having a relationship with Vicky. He has already told me that he will go out with her. Take care"*

4.29 Calls back were rejected and Andrews friend contacted his family at Andrew's home, who then called the Police at 3.03pm, providing a description and some details of his car and the recent concerns for Andrew. An "observation call" was issued, but no contact was made with the Family to gather more information or to inform the progress of the incident.

4.30 Further calls are made regarding the children and the possibility that Andrew was intending to go to see them at school, but no link is made to the potential for Andrew to be with Victoria.

4.31 A further call is made by Victoria's Sister to inform the Police at 4.10pm that Victoria had not picked up her children from school, that the curtains were closed at her home and that her husband had threatened suicide.

4.32 Thames Valley Police had not resourced the call between 3.03pm and 4.39pm, when an "immediate attendance" call was issued in response to the escalating situation identified from the calls made by the family.

4.33 TVP have again learnt from the call handling issues raised thorough this case, acknowledging that the failure to escalate the call and to dispatch Officers in a more timely fashion all came together to delay the response. Sadly, even if more urgent action had been taken, it cannot be assumed that the response could have made any difference to the outcome of the incident.

4.34 Officers attended the incident at Buttercup Close at 4.49pm, forcing entry at 5.00pm. Victoria was found on the floor at the bottom of the stairs, cold and not breathing. The opinion of the paramedic and the Doctor providing the death certificate is that Victoria was dead when Officers got to her.

4.35 Following the discovery of Victoria and following the reports from the family, attention turned to the concern that Andrew may carry out his threat to harm Person C and Police were despatched through contact with the local force to Person C's home in Leicestershire. Person C reported that he was never worried that Andrew would challenge or harm him.

4.36 On Monday the 20th October 2008, a local gamekeeper saw a person sitting in a car off Catmore Road, West Ilsley, at about 4.30pm and again at 8.00pm. On the second occasion, the gamekeeper checked with the occupant of the car, but was given no cause for concern, the occupant indicated he was fine.

4.37 On Tuesday the 21st October, Andrew was found in his car off Catmore Road W Ilsley, a post mortem found he had died from a single incised wound to his left arm and had bled to death.

5 Conclusions

General issues

5.1 The procedure and methodology for conducting internal service reviews should be reviewed and further guidance issued by Government to support the effective and sensitive conduct of similar reviews, The progress of internal learning and disciplinary processes running alongside the process for the Domestic Violence Homicide Review should be addressed to ensure that there is no delay to either the DVHR process or to subsequent Coroners Inquest procedures, criminal trials or disciplinary investigations..

5.2 The period dedicated to all Internal Management Reviews, including those conducted by the Police Service should be fixed through further guidance to be coterminous with the DVHR process, to ensure co-ordination between the two procedures.

5.3 Data Protection rules meant that the initial contact details of those involved were not easy to access, relying on third parties to assist, potentially hampering the smooth initiation of the review.

5.4 Consideration should be given to adding agencies such as the armed forces and Territorial Army, as well as the Voluntary Sector to those required to provide relevant evidence to DVHR's.

Thames Valley Police

5.5 The TVP Internal Management Review provided clear and unambiguous background information, outcomes of investigations with the staff and officers involved and identified the weaknesses in implementation of existing procedures, and the need for additional training or policy review that emerged from it.

5.6 Subsequently, it has been confirmed that the proposed mandatory training sessions linked to the changes in Force Standard Operating Procedure for Control Room and Call Handling teams have been implemented and will continue through to January 2010.

Victoria's contact with Thames Valley Police

5.7 It is clear that the opportunity to provide support, advice and assistance to Victoria was lost when, on the 14th October, the call by Victoria to TVP was not handled within the Force Standard Operating Procedure (SOP) for responding to reports of Domestic Violence.

5.8 The Call Operator failed to comply with the Standard Operating Procedure for dealing with domestic violence and as a result the opportunity was lost for Thames Valley Police to consider attendance, offer advice and offer referral to any support agencies.

5.9 The Call Operator failed to make these records, mention any option to record the calls and provide a call reference or to offer any concrete referral to local support agencies. Such agencies as Berkshire Women's Aid 24 hour helpline or the West Berkshire Domestic Abuse Unit (office hours) would have been able to offer some advice and support in the first instance.

5.10 The failure to record the report or to ensure a follow up in accordance with the SOP meant that Victoria had the clear view as expressed to friends and family that there was nothing she could do apart from encouraging Andrew to seek help from another agency. It cannot be known whether this prevented Victoria from taking action and receiving support that may have created an intervention in the course of subsequent events.

5.11 The creation of a call log should have occurred at the point Victoria contacted TVP for advice. Although existing IT systems do not dynamically link, such a record may have assisted in an earlier identification of the potential urgency of the incident on the day of the homicide.

Response on the 20th October 2008

5.12 The response on the day of the incident is clearly insufficient; TVP should have acted more swiftly and urgently to the calls on the day of the homicide, through escalation of the report as required in the procedure possibly resulting in a more urgent despatch of officers in response to the call.

5.13 The initial call by Person D was recorded as "fear for welfare" and graded "urgent attendance" but no officer was sent to see Person D nor was contact positively made to gather more details about the circumstances. Instead the "observation" message was despatched to local officers with scant information and description of Andrew.

5.14 Once the details of Andrew's car had been received from the family, an unnecessary delay in the process as the Police have direct access to the DVLA records, this was not passed to local officers to update the previously issued observation message.

5.15 The impending shift change meant that attendance at the homicide was deferred on 5 occasions, noting the shift change as a reason in one instance by the Radio Operator.

5.16 The Radio Operator failed to escalate the call and should have referred the failure to resource to his Supervisor, who in turn would have escalated the call to the local patrol supervisor. There was no link to the missing persons database and no unit was despatched as a result of this and the failure to escalate in line with the SOP on Missing Persons.

5.17 There was no further response until after 24 minutes from the call from Person B to report that Victoria had failed to pick up her children from school. This call was linked to the threat of Andrew to commit suicide, initially graded as "urgent attendance" and then to "immediate attendance".

NHS Berkshire West

5.18 The only contact with either Victoria or Andrew in respect of the background to this homicide had been with Andrew following his assisted visit to the GP on the 11th September 2008 and again on three other occasions.

5.19 Through the Significant Event Review of the case carried out jointly by Dr1 & Dr2 on 22nd October, they confirmed that there was no evidence of potential risk regarding domestic homicide for the following reasons: *"no evidence of previous threats, forced sexual contact, actual violence against any person.*

5.20 There was no record of contact with NHS services, apart from Andrew's visits to GPs – Drs 1 and 2 on the part of either Victoria or Andrew.

5.21 The background circumstances were identified as marital and emotional problems and depression was diagnosed, with medication prescribed. The visit to the Samaritans was known and a PHQ9 had been used to assess suicidal ideation and intent, in line with standard procedures. When pressed, Andrew denied any planning or intent, which was duly recorded in the notes.

5.22 The GP Practise ran the Significant Event Review process in a timely manner after the homicide and ensured an appropriate contact point and response to the incident once notified.

5.23 The Significant Event Review, and medical notes, were reviewed by a GP external to the Practise, in order to inform the IMR of NHS Berkshire West. There was no evidence of inappropriate decision making, record keeping or action taken.

5.24 Appropriate policies and procedures were in place to respond to the family.

West Berkshire Council

5.25 Evidence of involvement with the family was recorded in the Revenue and Benefits Service, with a Housing Benefit application being recorded from Victoria on the 16th October 2008.

5.26 The Head Teacher of the children's school confirmed that at no point did anyone raise any concerns with the school about the family prior to the homicide. There were no signs at school that the marital breakdown had any impact on the children. Attendance and academic achievement were good for both children.

5.27 Adequate and appropriate policies and procedures were in place up to and including the time of the deaths of Victoria and Andrew.

Colleagues at Lilliput Day Nursery, **Thatcham**

5.28 Colleagues were aware of the tensions in the marriage but were not alert to any direct or immediate threat to Victoria or to anyone else. Victoria appears to have shared some of her concerns about her marriage and about Andrew with her colleagues, but there was no mention of her relationship with Person C.

5.29 The team were clear that as they put it, *"nobody saw it coming"* but that after Victoria's homicide, they "*subconsciously knew that they thought it was going to happen";* although they could not identify any one thing or incident that would have prompted them to do anything. There was discussion about whether there should have been additional questioning of Victoria about the situation.

5.30 Significantly, the team concluded that even if there had been anything to prompt further action, none of them would know what to do with that information in order to prevent something happening, saying *"who would we report it to?"*

5.31 Victoria's colleagues felt that there is a clear need for people to be better informed about domestic abuse, and that their experience in the area of safeguarding children was relevant.

Family reflections

5.32 Andrew's family were clear in their view that, prior to Victoria leaving the family home, they were unaware that there were any problems between Victoria and Andrew in their marriage. They did not know that there was any need for help.

5.33 This concurs with the impression gained that Andrew was a very private person who did not discuss or explore issues with family and it appears not with his Mother and Father.

5.34 Victoria's Mother, Person A and her Sister, Person B were both aware of tensions in the marriage prior to the homicide on the 20th October. They were aware of the background to the tensions through their relationship with Andrew over years.

5.35 Andrew is described by Victoria's family as un-communicative, a bully, as spending little time with his children, and concentrating on model making, use of the internet and attending the Territorial Army drills and exercises. His relationship with Victoria is typified as suspicious and controlling, with his approach manipulative in his relationships.

5.36 Support for both Victoria and Andrew had been forthcoming from both Person A and Person B, evidenced by the amount of time spent talking through issues, arranging and transporting Andrew to the GP and allowing him to stay at Person A's home for a period until he could move back to the family home.

5.37 Both Person B and Person A had suggested and supported approaches to Relate or for some other form of support to assist them in sorting out their marriage tensions. Despite this, and Victoria's similar approach at an earlier date, Andrew was not willing to do this.

5.38 Both Person B & Person A's first concern was and is for the children, with each of them seeking to help sustain the marriage, prevent Victoria from being hurt in the subsequent break up and providing the support to Andrew, seeking not to take sides in the situation.

5.39 Neither was aware of any direct threat to Victoria from Andrew, but both were aware of his feelings about Person C and his threats to him, and to harm himself.

6 Recommendations

Thames Valley Police

6.1 The training currently underway in TVP should form part of an annual refresher session for all customer facing call centre or control room staff to ensure that the potential for Domestic Abuse is always uppermost in their minds. The training should use real case studies to explore and develop awareness of the ways in which people may report Domestic Abuse, the use of open questioning techniques and the use of domestic abuse risk indicators as well as the links to mental health issues and missing person's protocols.

6.2 External or partnership trainers with expert and current experience of Domestic Abuse should be invited to assist with this training to challenge existing internal cultures that may be a blockage to improved services.

6.3 The Standard Operating Procedure should be annually reviewed in response to new cases and audits of relevant case studies to ensure it is always fit for purpose. Relevant training or coaching should be carried out to refresh staff as required.

6.4 The National Standard of Incident Reporting should similarly be annually reviewed in the same manner to ensure it is fit for purpose. Relevant training or coaching should be carried out to refresh staff as required. An annual audit of compliance should be conducted to ensure that the procedures are accurately followed and findings fed back through the review of the annual training plan.

6.5 Control Room & Call Handling teams should receive regular and at least annual refresher training of Domestic Abuse awareness, the use of the SOP and the requirements of the NSIR, particularly in relation to apparent low level requests for advice.

6.6 Through a multi agency working approach, participate with the Council in a media campaign to raise the awareness of the residents, employers and businesses of West Berkshire to the wider potential of Domestic Abuse to affect their family, neighbours, staff and friends.

6.7 Contribute to the scoping and development of an effective "First call" or "Alert" service, with West Berkshire Council and NHS Berkshire West that supports and encourages residents to seek advice and guidance in responding to potential risks from Domestic Abuse.

NHS Berkshire West

6.8 That exploration of the use of screening tools in primary care is completed and recommendations implemented as required

6.9 That consideration is given to provision of regular training regarding Domestic Abuse / Homicide within the Child Protection Training currently available

6.10 That further work is undertaken to clarify the reporting requirements of Independent Contractors following Serious Untoward Incidents.

6.11 Develop a system that GP's may use to alert statutory agencies in partnership to identify potentially critically dangerous abuse to ensure access to appropriate services and to provide protection for potential victims.

6.12 A response to these recommendations should reflect the guidance provided in the Department of Health publication 292071 "Improving safety, reducing harm, a practical toolkit for front-line practitioners" published in 2009.

West Berkshire Council

6.13 Policies, procedures and guidance should be regularly reviewed and the provision of training for Council staff and Members be programmed annually to ensure the awareness of Domestic Abuse in all its forms is maintained at a high level.

6.14 Use the Councils facilities, resources and influence to increase for all residents of West Berkshire awareness of what constitutes abusive behaviours to challenge the narrow understanding that only physical abuse is serious.

6.15 Consider all types of media coverage, including posters in all Council offices, and public service points, vehicle sides, the use of Council and partner's newsletters, radio campaigns and in partnership with other agencies and central Government the use of television campaigns.

6.16 This approach could also use neutral points of access, either in person or through a secure and confidential web based service, such as Libraries, schools, community centres, children's centre's and leisure centres, through regular surgeries or other forms of access.

Other considerations for action

6.17 The procedure and methodology for conducting internal service reviews, the progress of internal learning and disciplinary processes relative to the process for the Domestic Violence Homicide Review should be addressed through further guidance to ensure that there is no delay to either the DVHR process or to subsequent Coroners Inquest procedures.

6.18 The period dedicated to all Internal Management Reviews, including those conducted by the Police Service should, through further guidance, be fixed to be coterminous with the DVHR process, to ensure co-ordination between the two procedures.

6.19 Future Government guidance needs to provide the review process with the right to access personal information through relevant agencies who hold it, to allow the review to proceed, especially where individuals are not inclined to offer or press for their involvement.

6.20 Consider the development of a properly funded and resourced "first call" or "alert" service for people to report concerns to encourage access to confidential advice and support from expert and trained staff, similar to the "Childline" service. This may be linked to safeguarding children to reinforce the fact that children are often victims in such cases.

6.21 Develop a partnership strategy and campaign to ensure there are policies in place with all major employers and encourage smaller employers to participate through joint training sessions that are mandatory for all staff. Draft and approve a statement of intent or charter that all employers in West Berkshire will be invited to sign up to in challenging domestic abuse in all its forms. There are both national and local organisations that may be interested, the most recent campaign is "4 ways to speak out" run by "Refuge" (http://www.fourwaystospeakout.co.uk/) or locally Berkshire Womens Aid (http://www.berkshirewomensaid.org.uk/) may wish to participate in an awareness raising campaign in West Berkshire.

6.22 As part of the wider campaign, with Police and NHS organisations, ensure a poster and leaflet campaign is maintained with free literature available to all residents, agencies and businesses in West Berkshire to use in all public areas and facilities and through staff induction and training. A "key signs to look for" approach should be utilised along with a link to a confidential reporting facility.

6.23 Post incident support frameworks should be examined to seek whether there is the potential to provide a range of services to include financial or

welfare benefit advice, advocacy, legal advice or support and broader family support. This is especially so where children are involved.