DOMESTIC VIOLENCE HOMICIDE REVIEW

IN THE CASE OF V1 AND S1

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Chair: **Maureen Noble**

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1 Introduction

Domestic Homicide Reviews (DHRs) were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). This provision came into force on the 13th of April 2011. This Act makes it a statutory responsibility for Community Safety Partnerships (CSPs) to complete a Domestic Homicide Review (DHR) when a case meets the criteria set in the guidance.

Following the publication of the Home Office Action Plan in March 2012 (particularly Action 74, which gave a commitment to "review the effectiveness of the statutory guidance on Domestic Homicide Review"), guidance on the conduct and completion of DHRs has been updated.

The Safer Chorley and South Ribble Community Safety Partnership (C&SR CSP) has commissioned this Domestic Homicide Review. The Review has been completed in accordance with the regulations set out by the Act, referred to above, and with the revised guidance issued by the Home Office to support the implementation of the Act.

The Review Panel wishes to acknowledge the sad and tragic circumstances surrounding this case and to offer its sympathy to the family of the subjects of the case.

The Chair of the Panel wishes to express her personal appreciation to the colleagues and family members who have contributed to the completion of this review – particularly so for their time, co-operation and patience.

Terms of Reference

The over-arching purpose of a Domestic Homicide Review (DHR) is to:

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

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

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

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

The rationale for the review process is to ensure agencies are responding appropriately to victims of domestic violence and abuse by offering and putting in place appropriate support mechanisms, procedures, resources and

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interventions with an aim to avoid future incidents of domestic homicide and violence.

The Home Office definition of domestic abuse and homicide is employed in this case and this definition is attached to this report.

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Background and events of the case

The subjects of the Review

Anonymity

The two subjects in this case are referred to as V1 (the female victim and wife of S1) and S1 (the male perpetrator, husband of V1). The table below shows the composition of the key persons pertaining to this case

Key person	Relation to the subject of the DVHR	Address at the time of the incident
V1	Subject – female victim	Address 1
S1	Subject – male perpetrator and husband of V1	Address 1

V1 and S1 had lived at Address 1 for a considerable number of years and were settled in their community.

Diversity issues

There are no known diversity issues to report pertaining to the subjects of this case.

Incidents leading to the death of V1 and S1

On Sunday the 11th of August 2013, S1 drove to Location 1, parked his car and walked to the railway line. At approximately 10:50 AM, S1 stepped onto the railway line, in front of an oncoming train. At approximately 11:20 AM a Paramedic from the North West Ambulance Service attended the scene and recorded that S1 was deceased at the scene.

The death of S1 was classed as 'non-suspicious' and a process of establishing and informing the next of kin commenced.

During the evening of the 11th of August, following a process to identify the next of kin, Officers from the British Transport Police attended Address 1. The Officers found the body of V1 at Address 1. A Paramedic from the North West Ambulance Service attended the scene and pronounced that V1 was deceased at the scene. It appeared that V1 had been stabbed and that this had been the cause of her death.

Police Notification to the Safer Chorley and South Ribble CSP and submission to the Home Office

The Lancashire Constabulary, in a communication to the Chair of the Safer Chorley and South Ribble Community Safety Partnership on the 16th of August 2013, issued a formal notification of the homicide of V1.

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The Lancashire Constabulary did not know the subjects of this case and there was necessary debate as to whether, in light of this, the case satisfied the criteria for a Domestic Homicide Review.

Colleagues from the Community Safety Partnership and the Lancashire Constabulary discussed the incidents within the context of Section 9 of the Domestic Violence, Crime and Victims Act 2004 and concluded that the circumstances of the case satisfied the criteria to undertake a full independent Domestic Homicide Review.

On the 12th of September 2013, the Chair of the Safer Chorley and South Ribble Community Safety Partnership issued a letter confirming the decision to undertake a Domestic Homicide Review in accordance with the Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews. The Chair confirmed that the Review would be undertaken by a specifically constituted DHR Panel that would report to the Chair and, in turn, to the C&SR CSP. The same notification was issued to the Home Office, with the expectation being that the Review would be completed within six months.

The Chair of the C&SR CSP invited colleagues to work towards identifying an appropriate Author for, where necessary, individual management reviews and short reports.

The CSP then undertook the process of commissioning an independent Chair for the DHR Panel and an independent Author to write the DHR Overview Report and Executive Summary.

On the 31st of March 2014, the Chair of the C&SR CSP contacted the Home Office with an update outlining the reasons why the completion of the DHR had been delayed, specifically:

- Recruiting a suitable Chair and Author to support the work of the Panel
- The provision of a safe e-mail system in accordance with the Government Connect Guidance for external partners
- Ensuring that agencies involved in the DHR were operating in accordance with the necessary information sharing protocol
- Giving time to family members to consider their involvement in the Review.

Criminal investigation and proceedings

There were no criminal proceedings and no safeguarding reviews to address during the DHR Review process. The Chair of the DHR Panel informed the local Coroner of the Review procedure and its time of completion.

Time Period under Review

The time period under review was agreed by the DHR Panel to be from the 11th of August 2012 until the 12th of August 2013. As is usual, the Authors of Individual Management Reviews and Short Reports were invited to exercise

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their discretion when submitting information out-with these dates and to do so if they considered the information to be relevant to the context of the case.

Additional Sources of Information

Prior to the initial meeting of the DHR Panel, the Chorley and South Ribble Community Safety Partnership sought information concerning the subjects of this case from a number of organisations. The following services were contacted and reported 'no contact' with the subjects prior to the incident:

- Lancashire County Council (Safeguarding Adults and Safeguarding Children Lead Officers)
- Lancashire Constabulary
- Police and Crime Commissioners Officer
- Lancashire Care NHS Foundation Trust (Drug and Alcohol Services)
- Domestic Violence Service
- Refuge Service
- North West Ambulance Service NHS Trust
- Home-Start
- Citizens Advice Bureaux

In addition to Short Reports from local agencies the panel sought information from other relevant services and individuals. These additional sources of information included a statement from the Manager of the Care Home where the Mother of S1 is a resident; statements from the two Officers from the British Transport Police who attended Address 1 (as a part of the investigation conducted by the Lancashire Constabulary) and a statement from the neighbour of V1 and S1.

The Chair of the Panel, along with a representative of Lancashire Constabulary, met with members of the family of V1 and S1 and also with a work colleague of S1. The insight provided by the family and work colleague is not collated in one discreet section of this report, rather it is reflected throughout the report, particularly so in the recommendations. The panel is indebted to the family and colleague for their contribution.

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Chronology

An integrated chronology has been drawn together for the consideration of the Panel. A synopsis of the key elements of the chronology is set out below. A full copy of the chronology is available on request from the C&SR CSP.

Agency	Dates	Subject of the case	Issue and outcome	Comments
Age Concern Lancashire	June 2010	S1	S1 sought advice concerning home care for his Mother. A Community Advisor provided information.	
	October 2010	V1	The Advisor made a follow up call. V1 responded positively to the advice received by S1.	
GP and Lancashire Teaching Hospital NHS Foundation Trust	August to November 2012	S1	Routine care and treatment provided for a long-term orthopaedic condition.	
GP1 and GP2	November to December 2012	V1 S1	Routine care appointment to monitor blood pressure. Management of a long-standing orthopaedic condition. Appointment concerning palpitations.	A normal heart trace was recorded and a cardio-vascular risk assessment was

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				completed.
GP and Lancashire Teaching Hospital NHS Foundation Trust	June 2013	S1	Management and treatment of a long-standing orthopaedic condition.	
Department for Work and Pensions	July 2013	S1	To check the suitability of S1 to become his Mother's "appointee".	
GP	July 2013	S1	Appointment concerning S1 not sleeping well and concerns regarding his Mother.	Assessment undertaken and nothing disclosed to suggest suicidal or homicidal thoughts.
Department for Work and Pensions	August 2013	S1	PC (Pension Credit) forms are received – signed and dates by S1	
Lancashire Police; British Transport Police and North West Ambulance Service	11th of August 2013	V1 S1	Homicide and suicide incident occurs. S1 and subsequently V1 are discovered deceased and the investigation commences.	

*On the 12th of August 2013, the Department for Work and Pensions processed the forms signed by S1 and recorded on their systems the pension income and change of address of the Mother of S1.

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Governance

A DHR Review Panel was established by the Safer Chorley and South Ribble Community Safety Partnership (C&SR CSP) and met on three occasions to oversee the process. The Panel received reports from agencies and dealt with any associated matters such as family engagement, media management and liaison with the Coroner's Office.

The Community Safety Partnership appointed an Independent Chair to oversee and direct the Review, in accordance with the Home Office Guidance. In this case, the role of the Chair was taken my Ms Maureen Noble. Ms Noble has extensive experience in safeguarding and public protection practice and an extensive portfolio of serious case review experience – for both adult and child homicides.

In turn, an independent author, Mr John Doyle, was appointed to write the overview report.

There were no conflicts of interest recorded during the Review. Authors of Management Reviews and Short Reports were not directly connected to the subjects of the case and did not sit on the Review Panel.

Specific Key Lines of Enquiry

The initial Panel meeting, held on the 9th of January 2014, discussed and agreed a set of Key Lines of Enquiry. These key lines are set out below:

- Were the services offered by your agency accessible, appropriate and sympathetic to the presenting needs of the subjects of the case?

- Did your agency have knowledge of domestic abuse of the victim? If so, how was this knowledge acted upon?

- Did your agency undertake any specific assessments or enquiries in relation to domestic abuse of the victim?

- Was your agency aware of any allegations of domestic abuse in relation to the perpetrator and if so, how did your agency respond?

- To your knowledge were the family and friends of the victims aware of domestic abuse and were they offered support in responding? Were there any confidentiality issues in relation to the family and friends being aware of domestic abuse?

- Was the impact of alcohol, drugs or mental health issues properly assessed or suitably recognised? What action did your agency take in identifying and responding to these issues?

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- Were there any specific diversity issues relating to the victim and/or the perpetrator.

- Were issues with respect to adult and child safeguarding adequately assessed and acted upon?

- Were there any issues in relation to capacity or resources in your agency that had an impact on the ability to provide services to the victim and to work effectively with other agencies?

- Was information sharing within and between agencies appropriate, timely and effective?

- Were there effective and appropriate arrangements in place for risk assessment and the escalation of concerns?

- Do you have a domestic abuse policy that includes guidance, training or supervision for your employees or service users who may disclose domestic abuse?

- Is your domestic abuse policy up to date and effective?

- Was it reasonably possible for your agency to predict or prevent the harm that came to the victim?

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The Home Office Definition of Domestic Violence

In March 2013, the Government introduced a new cross-government definition of domestic violence and abuse, which is designed to ensure a common approach to tackling domestic violence and abuse by different agencies. The new definition states that domestic violence and abuse is:

> "Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:
>
> - psychological
> - physical
> - sexual
> - financial
> - emotional
>
> "Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.
>
> "Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

This definition, which is not a legal definition, includes so-called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

A member of the same household is defined in Section 5 (4) of the Domestic Violence, Crime and Victims Act (2004) as:

a. a person is to be regarded as a "member" of a particular household, even if he does not live in that household, if he visits it so often and for such periods of time that it is reasonable to regard him as a member of it;

b. Where a victim lived in different households at different time, "the same household as the victim" refers to the household in which the victim was living at the time of the act that caused the victim's death.

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Establishing the domestic homicide review

The Safer Chorley and South Ribble Community Safety Partnership (C&SR SCP) Domestic Homicide Review Panel held its initial meeting on 9th of January 2014 and confirmed that the death of V1 and S1 met the criteria for a domestic homicide review (DHR).

Domestic Homicide Review Panel

Designation	Agency
Chair of the Panel	Independent Practitioner
Author of the report	Independent Practitioner
Chair of the C&SR CSP	Chorley and South Ribble Community Safety Partnership
Detective Chief Inspector	Lancashire Constabulary
Detective Inspector	Lancashire Constabulary
Reviewing Officer	Lancashire Constabulary
Head of Safeguarding	Chorley and South Ribble Clinical Commissioning Group
Community Safety Manager	South Ribble Borough Council/ Chorley Council
Community Safety Officer	South Ribble Borough Council
Legal Services Manager	South Ribble Borough Council
Admin Manager/ Minute Taker	South Ribble Borough Council
Senior Probation Officer	Lancashire Probation Trust
Community Safety & Justice Coordinator	Lancashire County Council

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Agencies Submitting Individual Management Reviews (IMRs), Short Reports and/or supporting information

The Chorley and South Ribble Community Safety Partnership discussed the case prior to the formation of the DHR Panel and identified a number of agencies that would be contacted to assist with the review. The following agencies were then invited to submit information to the review Panel:

Agency	Type of report	Reason for request	Completed and submitted by:
Lancashire Constabulary	DHR Short Report	Lancashire constabulary attended Address 1 and completed an investigation into the incident	A Sergeant who is retired from the Greater Manchester Police Service and is commissioned as a Review Officer (to support the completion of DHRs, Serious Case Reviews and other statutory reviews) within the Force Public Protection (Compliance) Unit. The Author had no professional involvement in the case prior to completing the Short Report
British Transport Police	Statements from Attending Officers were sought as a part of the investigation	Officers from the British Transport Police attended the scene of the incident at Address 1	Two Police Constables employed by the British Transport Police provided statements to assist Lancashire Constabulary in their investigation.
Department for Work and Pensions. The Pension Service	DHR Short Report	The Department had contact with S1 prior to the incident occurring	A member of staff employed by the Department for Work and Pensions with responsibility for Liaising with Local

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			Authorities. The Author had no professional involvement in the case prior to completing the Short Report.
Age Concern Central Lancashire	DHR Short Report	Age Concern Central Lancashire had contact with S1 prior to the incident occurring	An Executive Director at Age Concern Central Lancashire, who is responsible for ‘Help Direct’ services within Preston and South Ribble. The Author had no professional involvement with the case prior to completing the Short Report. The Short Report was quality assured by the Deputy Chief Executive of Age Concern, Central Lancashire.
Age UK Lancashire	DHR Short Report	An invitation was passed to the agency to ascertain if contact had been made with any subjects in this case	Chief Executive of Age UK, Lancashire. The Author had no professional involvement with the case prior to submitting the Short Report.
Little Sisters of the Poor Care Home	Summary Report	The Care Home had contact with S1 prior to the incident occurring.	The Manager of the Care Home submitted a brief report constructed from care records and recollections of the interactions between her and the subjects of the case.

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Lancashire Teaching Hospitals NHS Foundation Trust	DHR Short Report	The NHS Foundation Trust had contact with S1 prior to the incident occurring	The Lead Officer for Adult Safeguarding and a member of staff at Lancashire Teaching Hospitals NHS Foundation Trust. The Author had no professional involvement with the case prior to submitting the Short Report. The Short Report was Quality Assured by the Director of Nursing
NHS England (for General Practice)	DHR Short Report	GP1 (the Practice for V1) had contact with V1 during the scope of the review; GP2 (the Practice for S1) had contact with S1 during the scope of the review.	Lead GP for Safeguarding with NHS Chorley and South Ribble Clinical Commissioning Group. The Short Report was quality assured by the Assistant Director of Nursing, NHS England. The Author had no professional involvement with the case prior to the submission of their Short Report.
North West Ambulance Service NHS Trust	Chronology on the day of the incident	Attendance at the scene at Address 1	The Operations Manager for South West Lancashire. The Author had no professional involvement with the case prior to the submission of the chronology.
Neighbour of V1 and S1	Personal Statement	A neighbour of V1 and S1 for over 25 years	A personal statement was

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			issued by the neighbour as a part of the investigation into the incident.
Work colleague of S1	Meeting with the Chair of the Panel and representative of Lancashire Constabulary	Work colleague of S1 for a number of years	A personal account to provide insight for the consideration of the Panel

No other reviews were being undertaken during the time-line of this review.

Brief synopsis of Agency involvement

Agency	**The level of contact with the subjects of the Review**
Lancashire Constabulary & British Transport Police	Lancashire Constabulary had no contact with V1 or S1 prior to the incidents that led to their death. There are no records of Police attendance at Address 1 prior to the incident. Lancashire Constabulary did not know the subjects of this case prior to the events that occurred. Additionally, two Police Constables from the British Transport Police attended Address 1 and discovered V1. They commenced a scene log, contacted the North West Ambulance Service, escorted the attending Paramedic and ensured the scene was secure until relieved by colleagues from the Lancashire Constabulary.
Department for Work and Pensions. The Pension Service.	The Department for Work and Pensions had contact with S1 prior to the incident occurring. The contact centred upon providing assistance and advice to manage the affairs of the Mother of S1, who was in the process of being admitted to a care home.
Age Concern – Central Lancashire	'Help Direct' – one of the services provided by Age Concern Central Lancashire – had contact with S1 prior to the incident occurring. The nature of the contact focused upon providing advice concerning "care funding" and a follow-up telephone call.
Age UK Lancashire	Records were checked and it was confirmed that there had been no contact with any subject of this

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	case either by employees of volunteers working for Age UK Lancashire during the time line of this review.
Little Sisters of the Poor Care Home	Records confirmed that the Care Home had contact with S1 prior to the incident and this contact centred upon managing the admission to the Care Home of the Mother of S1 and, subsequently, providing care for the Mother of S1.
Lancashire Teaching Hospitals NHS Foundation Trust	Lancashire Teaching Hospitals NHS Foundation Trust had no record of contact with V1 during the timeline of this review. Records showed that the Hospital had contact with S1 during the scope of the Review. This contact was to provide services to manage the pain resulting from a chronic musculo-skeletal condition.
NHS England (for General Practice)	GP1 and GP2 had long-standing contact with V1 and S1, providing primary healthcare services as their Family Practitioner.
North West Ambulance Service (NWAS) NHS Trust	A Paramedic attended the scene at Address 1 and pronounced that V1 was deceased at the scene.
Neighbour of V1 and S1	The nature of the contact was as a neighbour to V1 and S1 for over 25 years. The nature of the statement concerns a recollection of events on the day the incident occurred.

The information sources

When constructing their respective Short Reports and submissions, the agencies involved analysed information and data from their own specific and systematic sources. The sources of data and information are summarised below:

Agency:	**The sources of information and method employed**
Lancashire Constabulary & British Transport Police	The Police National Computer holds information about a subject's previous convictions and arrests; the nature of all recordable offences and information about Court disposals. Lancashire Constabulary creates incident logs on a system called

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	"Webstorm". Incident logs are given a Unique Reference Number (URN) and these are linked to the other systems. The "Sleuth" system holds intelligence records within its database. It also holds the Protecting Vulnerable People (PVP) data including Vulnerable Children (VC), Vulnerable Adults (VA), Missing Persons and Domestic Abuse (DA) victims and offenders. Police Officers and staff complete these databases when they attend incidents and are processed through the Multi-Agency Safeguarding Hubs (MASH). Statements were taken from two Police Constables employed by the British Transport Police who attended the scene at Address 1
Department for Work and Pensions. The Pension Agency.	Report from the Visiting Officer and DWP forms recorded on the DWP system.
Age Concern – Central Lancashire	The Help Direct secures on-line 'Customer Response System' (known as CRS).
Age UK Lancashire	Record of contacts with Age UK.
Little Sisters of the Poor Care Home	Following a conversation and meeting between the Manager of the Care Home and the Community Safety Officer (Vulnerability) from the Safer Chorley and South Ribble CSP, the submission was made from relevant care notes and personal recollections from the manager and staff.
Lancashire Teaching Hospitals NHS Foundation Trust	Appropriate Hospital Records.
NHS England (for GP1 and GP2)	The Author of the Short Report took account of the information held

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	within the GP records for both V1 and S1 and from the conversations held with the GP1 and GP2 who provided health-care services to the subjects of this case.
North West Ambulance Service NHS Trust	Emergency Operations Centre (EOC) record of emergency calls; Sequence of Events (SOE) is an electronic record of events generated by the EOC; Patient Report Form

Analysis

Each Key Line of Enquiry (KLOE) is commented upon from material contained within the short reports, statements and the deliberations of the DHR Panel. Certain elements of the commentary could easily fit into more than one KLOE and so the decision on where it appears is made simply on a “best fit” basis.

The Key Line of Enquiry (KLOE) appears in *italics* followed by a considered view by the Panel.

KLOE 1

Were the services offered by your agency accessible, appropriate and sympathetic to presenting needs of the subjects of the case?

Considering the information provided by the Short Reports and other forms of information submitted to the Review Panel, it is clear that the correct and appropriate pathways of service had been applied by each service provider in contact with the subjects of the case prior to the incident occurring.

KLOE 2

Did your agency have knowledge of domestic abuse of the victim? If so, how was this knowledge acted upon?

None of the agencies involved in this Review had any knowledge of domestic abuse and no disclosures of abuse were made prior to the incident occurring.
Neither GP practice providing services to the subjects of this case had any knowledge of domestic abuse being an issue. The subjects of this case never spoke to their GPs of, or displayed any behaviour suggesting, domestic abuse could be taking place.
There was no communication from the Accident + Emergency Services, out of hours services or any other agency to alert either GP practice to the possibility of domestic abuse.

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The Lancashire Constabulary had never attended Address 1 on any matter prior to the incident occurring.

KLOE 3

Did your agency undertake any specific assessments or enquiries in relation to domestic abuse of the victim?

From the information submitted to the Panel, there was no disclosure of domestic abuse.
Both GPs are aware of the relevant guidance concerning the identification of domestic abuse. However, the application of this guidance was not relevant within the context of the consultations with the subjects of the case.
Agencies in contact with the subjects of this case, prior to the incident, maintained contemporaneous records of their contact and it is clear that there was no trigger to undertake assessments or enquiries into domestic abuse.
Lancashire Constabulary has relevant guidance and procedures in place but did not undertake an assessment because the Constabulary, prior to the incidents occurring, did not know the subjects of this case.

KLOE 4

Was your agency aware of any allegations of domestic abuse in relation to the perpetrator and if so, how did your agency respond?

None of the organisations or agencies involved in this Review reported any awareness, knowledge or suspicion of domestic abuse concerning the subjects of this case.
Lancashire Constabulary did not know the perpetrator.

KLOE 5

To your knowledge were the family and friends of the victims aware of domestic abuse and were they offered support in responding? Were there any confidentiality issues in relation to the family and friends being aware of domestic abuse?

None of the organisations or agencies involved in this Review reported any awareness, knowledge or suspicion of domestic abuse concerning the subjects of this case. Additionally, none of the organisations reporting to the Review highlighted any issues concerning confidentiality that may have prevented or affected the disclosure of information.
Lancashire Constabulary, as part of the investigation, established that there was no third party involvement in the deaths of the subjects of this case.

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Members of the family, a work colleague of S1 and the neighbour of V1 and S1 were interviewed and no one was aware of any domestic abuse and there were no confidentiality issues within the family or with friends concerning the issue of domestic abuse.

KLOE 6

Was the impact of alcohol, drugs or mental health issues properly assessed or suitably recognised? What action did your agency take in identifying and responding to these issues?

There was no known drug, alcohol or mental health issues pertaining to the subjects of this case reported by any of the agencies involved in the Review.
There was nothing in the medical records, from either GP Practice that suggested any family problems, mental health issues, excess alcohol use or domestic abuse. S1 had a consultation with his GP on the 26th of July 2013 and this may have been the first indication of a possible or potential mental health issue. GP2 had a good relationship with S1 and did a comprehensive assessment to rule out a depressive illness. He listened to his worries about his mother going into a nursing home and gave support and advice. There was no indication that S1 was having any suicidal or homicidal thoughts and no risks were identified. S1 did not seek any further service or intervention from his GP after this time.

KLOE 7

Were there any specific diversity issues relating to the victim and/or the perpetrator in this case.

There were no specific diversity issues pertaining to this case. Both V1 and S1 were White British citizens who had been married for over 30 years.
It is important to point out that V1 and S1 were 'older people' but there was no indication from the agencies involved in the Review (setting aside the management of existing medical conditions described in the chronology) that they were in any way vulnerable to a risk of harm.

KLOE 8

Were issues with respect to adult and child safeguarding adequately assessed and acted upon?

There were no issues concerning safeguarding identified prior to the incident occurring and none arose during the completion of the investigation into the incident.

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KLOE 9

Were there any issues in relation to capacity or resources in your agency that had an impact on the ability to provide services to the victim and to work effectively with other agencies?

None of the agencies involved in this Review reported any issues concerning their capacity or resources available to provide services to the subjects of the case or manage the investigation of the incident, including liaison with other agencies.
With regard to Lancashire Teaching Hospital NHS Foundation Trust, if any safeguarding concerns had been identified then an incident record would have been created on Datix, an internal computerised recording database. This in turn would generate, depending on the disclosure/circumstances a referral to Adult Social Care or the Police.

KLOE 10

Was information sharing within and between agencies appropriate, timely and effective?

All of the agencies involved in this Review reported that, where necessary and appropriate, the sharing of information was effective and efficient.

KLOE 11

Were there effective and appropriate arrangements in place for risk assessment and the escalation of concerns?

It was not possible for the DHR Panel to ascertain if <u>all</u> the organisations involved in the Review have suitable and appropriate procedures in place to escalate concerns relating to vulnerability and/or safeguarding.
With regard to General Practice, the Risk Assessment Procedure is drawn from the guidance issued by the Local Multi Agency Risk Assessment Committee (MARAC). General Practice has also adopted the GMC Guidance (2012) concerning the "7 Golden Rules of Information Sharing"
With regard to the Lancashire Teaching Hospital NHS Foundation Trust, the policy is linked to the Policies the Trust has concerning "Safeguarding Adults". Additionally, the Trust has a programme of mandatory training that incorporates all aspects of abuse, including domestic violence.
Lancashire Constabulary confirmed that they have a robust risk assessment and escalation policy and procedure.

A key element in the formulation of the recommendations associated with this review and discussed by the Panel focused upon the need to:

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- Ensure that in relation to risk assessment, safeguarding vulnerable adults and children, and domestic abuse, “independent” organisations (for example Age UK and Age Concern) commissioned by the public sector to provide services on their behalf, are required to adopt, as a condition of contract, the relevant policies and procedures approved by their commissioning body; and
- With regard to public bodies (for example the Department for Work and Pensions DWP), ensure that corporate policy developments are disseminated to all front line staff. The Panel noted that the DWP have a contract with an organisation called “Right CoreCare” to provide, amongst other things, confidential, one to one, professional help or advice on stress, bereavement, bullying and harassment, debt, child or caring responsibilities and a range of other personal issues? Promoting access to these services may enable DWP staff to manage the stress associated with addressing these issues with their clients and it may provide access to the operational architecture required to ensure that ‘concerns’ are transmitted to the correct personnel.
- Additionally, the Panel also noted the research conducted in 2012 concerning the introduction of two new policies regarding ‘Jobseeker’s Allowance Domestic Violence Easement’ (JSA DV Easement) and the ‘Destitute Domestic Violence Concession’ (DDV Concession) *. This research made a number of recommendations that could form the basis of addressing the issue of domestic violence and vulnerability in a wider context. The recommendations include:
    - Providing an environment where victims of domestic violence are comfortable in disclosing – e.g. making rooms available for one-to-one discussions
    - Replicating good practice where relevant and useful such as considering the benefits of establishing ‘DV leads’/single points of contact at Job Centre or district levels.
    - Making better use of opportunities for additional adviser training – where available through local multi-agency partnerships.

* Research conducted by Richard Lloyd and Dr Kath Mulraney, ICF GHK Consulting Ltd. This can be downloaded free from this website: **http://research.dwp.gov.uk/asd/asd5/rrs-index.asp**

KLOE 12

Do you have a domestic abuse policy that includes guidance, training or supervision for your employees or service users who may disclose domestic abuse?

As is the case with the response to KLOE 11, it was not possible for the DHR Panel to ascertain if all the organisations involved in the Review have a domestic abuse policy in place; whether the Policy is up

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to date; or whether there is training and supervision in place to – when necessary – enact the Policy.
With regard to the Lancashire Teaching Hospital NHS Foundation Trust, the Short Report Author confirmed that the Safeguarding Adults Policy is current (it will be reviewed by the Board in August 2014) and that the Trust has a programme of mandatory training that incorporates all aspects of abuse, including domestic violence. The Policies of the Trust are available on request.
General Practice has a Safeguarding Policy that mirrors the Policy of the CCG, though modified to take account of the Royal College of General Practice toolkit for General Practice.

Again, as with KLOE 11, a key element in the formulation of the recommendations associated with this review and discussed by the Panel stemmed from the responses to this KLOE

KLOE 13

Is your domestic abuse policy up to date and effective?

Please refer to the responses give to KLOE 11 and 12

KLOE 14

Was it reasonably possible for your agency to predict or prevent the harm that came to the victim?

All of the agencies involved in this Review reported that it was not possible to predict or prevent the incidents that led to the death of the subjects of this case.

Summary of analysis

The DHR Panel invited the submission of information concerning the subjects of this case from a wide range of agencies, as has been described above. All relevant agencies submitted information and, following consideration, the Panel sought additions and clarification on certain points from a number of those agencies. These clarifications were received in a timely fashion and incorporated into the final analysis.

Setting aside the issues that will be pursued within the section of this Overview Report concerning the recommendations, the Panel was satisfied that all necessary and appropriate procedures have been applied by all the services in contact with the subjects of this case prior to incident occurring.

The Panel considered all relevant elements of service provision and concluded that each agency applied its own service standards in an effective and apt fashion and that there is no suggestion of poor or sub-standard practice.

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Summary of the case

The Domestic Homicide Review Panel, when considering the key elements of this case and the potential to learn from them, considered the issues outlined below to be pertinent.

V1 and S1

- This is a case where two adults (V1 and S1), settled in their community with close family bonds, died. There were no obvious pressures that would trigger the incidents to occur and the outcome could not be predicted or prevented.
- The victim (V1) and perpetrator (S1) in this case had little formal contact with public service agencies prior to the incident cited in the review.
- The Lancashire Constabulary did not know V1 or S1 prior to the incident reported in the review.
- V1 and S1 were known by their GPs, GP1 and GP2 respectively.
- There was no recorded adult social care involvement with the subjects of this case prior to the incidents reported.
- There was no recorded involvement by the subjects of this case with the Lancashire Probation Trust.
- There was no involvement of Drug, Alcohol, Mental Health or Domestic Violence Services with the subjects of this case.

DHR process

- The homicide and suicide that occurred in this case does not seem to indicate that significant changes to the way services respond to clients could or should be made.
- The importance of involving all relevant agencies in the process of completing a DHR cannot be over-stressed.
- Producing a clear chronology is key to the DHR process – not just for the agency involved with the subjects but also for other agencies involved in the process
- To record the achievement of good standards of professional practice is important for all agencies when completing the DHR process. It supports both intra-agency and inter-agency learning and professional development
- Key Lines of Enquiry are a very important element in the DHR process. A considered response to each KLOE offers the DHR Panel the opportunity to, firstly, ascertain if the agency submitting information to the Panel complied with its own professional service standards and,

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secondly, whether the agency is in a position of preparedness with regard to issues such as tackling domestic violence and abuse.

Lessons to be learned

In addition to the information submitted by the agencies involved in the case, conversations with family members and the colleague of S1 has helped the Panel to formulate a number of recommendations and these are set out below.

During the course of the Review, it has been noted that the family of the subjects wished to acknowledge the professionalism of the services involved in managing the investigation of the incidents. They made specific reference to the invaluable support offered to them by the Lancashire Constabulary.

The Panel appreciated the submissions made by the two General Practices (GPs) who participated in the review, particularly the recommendations for action identified by the GPs. The Panel particularly welcomed the following:

- Both practices will raise staff awareness in relation to domestic abuse and consider the feasibility of routine questioning on domestic abuse for patients attending the practice. This will be in accordance with the guidance issued by the Royal College of General Practice which can be found at: http://www.rcgp.org.uk/policy/rcgp-policy-areas/domestic-violence.aspx

- Both practices to ensure that materials are readily available for patients in respect of support services for domestic abuse.

Recommendations

1. Providing support to adults who are caring for parents

Key issue considered by the Panel	This issue was raised by the family of the subjects of this case and was considered by the Panel. The family of V1 and S1 considered that it may have helped S1 to receive support and guidance concerning the management of the process of transferring his Mother into a residential home
Outcome intended by the Panel	The Panel could not identify a line of association between this issue and the incident. Nonetheless, the Panel agreed that it is important for agencies providing services to adults

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	who are caring for their parents to satisfy themselves that they have made available to their clients sufficient information concerning all of the responsibilities associated with this care. All agencies should satisfy themselves that they have taken account of the impact associated with the often complex and evolving role of becoming a carer and responded, as necessary, to this impact.
Recommendation for action	Each agency involved in this particular case should take time to reflect on their involvement with the subjects of the case and develop any necessary action learning points in order to satisfy themselves that their procedures will become sufficiently robust to offer information about the role of the carer, to offer a carer assessment, to engage with other services to share information in order to co-ordinate the provision of carer services and to determine when and where to intervene if the carer happens to express concern and anxiety about their role as a carer.

2. <u>Providing support to the family of victims – including children and grandchildren</u>.

Key issue considered by the Panel	This issue was raised by the family of the subjects of this case and was considered by the Panel. The family of V1 and S1 considered that it would be beneficial to consider the concept of the victim(s) of a crime in a broader context so that it includes children and grandchildren.
Outcome intended by the Panel	The Panel agreed that it is important for agencies providing services to the victim(s) of a serious crime to take account of the impact upon the wider family of the victim(s). All agencies involved in supporting

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	the victims of a serious crime, including organisations investigating the crime, should satisfy themselves that they have the capacity and capability to recognise the impact upon the wider family and how and when to respond when, for example, a parent expresses concern regarding the impact of the crime and its consequences upon a child or grandchild.
Recommendation for action	Each Agency involved in this particular case should take time to reflect on their involvement with the subjects of the case and develop any necessary action learning points in order to satisfy themselves that their procedures will become sufficiently robust to respond to concerns expressed by children directly or by parents on behalf of their children. These procedures may centre upon knowing when to share this information and with which organisation to share it with so that support can be offered in a timely and age-appropriate fashion.

3. <u>Ensuring all organisations have an up-to-date Policy on Domestic Abuse</u>

Key issues considered by the Panel	A number of the Agencies submitting information to support the completion of this DHR did not, in the view of the Panel, respond sufficiently well to Key Lines of Enquiry 10, 11 and 12. These KLOE concern arrangements to assess risk and escalate concerns (about abuse and vulnerability); the existence of a policy on domestic abuse that staff are aware of and understand; and whether the domestic abuse policy is up-to-date and effective. The Panel also discussed the matter

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	of ‘domestic abuse’ in its widest sense and concluded that it is neither a single impact nor a homogenous subject and should not be tackled as such. The Panel underlined the established view that the multi-agency response to domestic abuse should be clearly linked to the multi-agency response to safeguarding adults and children. The Panel welcomed the recommendations made by the two General Practices participating in the Review (as described above) and would encourage all GPs to adopt the same guidance. The Panel noted that the content and the quality of the information submitted by each agency are crucial for the efficient execution of duties by the Panel.
Outcome intended by the Panel	Organisations involved in the completion of this Domestic Homicide Review should adopt a model policy on domestic abuse and, periodically, review and assess the implementation of this Policy
Recommendation for action by the Panel	The pan-Lancashire DHR Task and Finish Group should consider the development of a model policy on Domestic Abuse and share this model with all participating agencies in this Review and invite them to consider adapting and then adopting the model Policy. Commissioning Organisations – who have service contracts with independent organisations – should consider the adoption of an effective policy on domestic abuse a formal condition of service. The Regional Manager for the Department for Work and Pension should be contacted and the outcome of this Review, along with its recommendations, should be shared with them.

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4. Providing high quality information for the DHR Panel

Key issue considered by the Panel	Receiving comprehensive information to support the Review in a timely fashion. Occasionally, individuals and agencies may have difficulty completing the template. The content and the quality of the information submitted by each agency are crucial for the efficient execution of duties by the Panel. The Panel also considered the question of providing training or "buddying" for colleagues who may be invited to be authors of IMRs and Short Reports for DHR Panels.
Outcome intended by the Panel	To improve the quality of the information considered by DHR Panels.
Recommendation for action by the Panel	Each Agency involved in this particular case should take time to reflect on their involvement in the DHR and develop any necessary action learning points in order to satisfy themselves that their procedures are sufficiently robust to manage the delivery of information to any future domestic homicide review.
Key stakeholder action required	In co-operation with the Safer Chorley and South Ribble Community Safety Partnership, each agency involved in this DH Review will, where necessary, be invited to construct and implement a learning action plan resulting from their particular experience of this review. This plan should focus upon how the organisation will respond to a DHR in future and particularly: • who in their organisation can and should author Short Reports and/or IMR and who can and should quality assure these reports • How to respond in a full and constructive way to both the

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	Terms of Reference and the Key Lines of Enquiry for DHRs. These elements of the DHR process are generally constructed in a standard format – though the precise wording may differ from Review to Review. The Safer Chorley and South Ribble Community Safety Partnership should monitor the delivery of this action.

Conclusion

The primary lesson in this case is a very difficult one to grasp because it was a totally unexpected and unpredictable incident.

It is accurate to suggest that the most inquisitive mind would not have been able to recognise that a situation such as the incidents described here in this review, were about to occur. The DHR Panel judged that the homicide of V1 and the suicide of S1 were neither predictable nor preventable within the period under examination.

Finally, the Panel would like to extend its sympathy to the family and friends of the victims in this case and to offer its condolence for their loss.

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Glossary

CSP	-	Community Safety Partnership
DHR	-	Domestic Homicide Review
FGM	-	Female Genital Mutilation
NWAS	-	North West Ambulance Service NHS Trust
DC	-	Durham Constabulary
GP1	-	General Practitioner 1
GP2	-	General Practitioner 2
OPUS	-	Operational Policing Unit System
FIS	-	Force Intelligence System
PNC	-	Police National Computer
EOC	-	Emergency Operations Centre (NWAS)
SOE	-	Sequence of Events
PRF	-	Patient Report Form
KLOE	-	Key Line of Enquiry
NHS	-	National Health Service
CCG	-	Clinical Commissioning Group
RRV	-	Rapid Response Vehicle (used by NWAS)
DA	-	Domestic Abuse
DV	-	Domestic Violence

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