Wokingham Community Safety Partnership

DHR 3 Overview Report

Concerning the death of:

Jane* - Died October 2016

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Completed November 2017, revised October 2019 and December 2020

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Summary of the incident

1.1 Summary of the incident

This Domestic Homicide Review (DHR) examines the circumstances surrounding the unexpected death of Jane[i] in Berkshire in October 2016.

The DHR was commissioned by the Community Safety Partnership (CSP) of Wokingham Borough Council (WBC) in January 2017.

On an evening in early October 2016 at approximately 23.27, Martin[ii] rang the 999 service from his home address. During that call, he stated that he had stabbed and killed his girlfriend, Jane. He also threatened to stab himself. Thames Valley Police officers attended Martin's home address and on arrival found Jane, deceased and Martin with stab wounds to his chest and abdomen.

Martin was subsequently conveyed to hospital for treatment. He underwent surgery, which is credited with having saved his life.

Later in October 2016 Martin was formally charged with murder. He appeared in court for trial in 2017 and pleaded guilty to manslaughter on the grounds of diminished responsibility and was sentenced to 14 years in prison.

The DHR panel wishes to express its condolences to the family of Jane and recognises the distress that the incident and this subsequent review brings. We hope this report will provide them with assurance that the circumstances of the involvement of local agencies have been properly and thoroughly reviewed.

1.2 Purpose of the Domestic Homicide Review

DHRs came into force on 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Adults Act (2004). The act states that a DHR should be a review '*of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:*

- *a person to whom he was related or with whom he was or had been in an intimate personal relationship, or*

- *a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death'.*

The purpose of a DHR is to:

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

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

c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

d) prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a coordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

e) contribute to a better understanding of the nature of domestic violence and abuse; and

f) highlight good practice.

1.3 Process of the review

A DHR was recommended and commissioned by the Community Safety Partnership in January 2017 in line with the expectations of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2013. This guidance is issued as statutory guidance under section 9(3) of the Domestic Violence, Crime and Adults Act 2004. It has since been updated and was republished in December 2016. This DHR has used this revised guidance in the development of this Overview Report.

The review process was completed in November 2017. This report was approved by the DHR panel prior to its submission to the Home Office. There was a delay in the completion of the DHR process, in part due to personnel changes within the Borough Council. This also led to a delay in submission to the Home Office. This report is a revised version that takes account of the feedback received from the Home Office Quality Assurance Panel in October 2019 and December 2020.

1.4 Panel Membership

Steve Appleton, Managing Director Contact Consulting - Independent Chair and Author

Public Health Consultant, Wokingham Borough Council

Adult Safeguarding Service Manager, Wokingham Borough Council

Head of Safeguarding, Berkshire West Clinical Commissioning Group

Head of Safeguarding South Central Ambulance NHS Foundation Trust

Corporate Lead for Safeguarding, Royal Berkshire Hospital NHS Foundation Trust

Head of Safeguarding, Berkshire Healthcare NHS Foundation Trust

Detective Inspector, Thames Valley Police

Commissioning Specialist, People's Services Strategy & Commissioning, Wokingham Borough Council

Business Manager Berkshire Women's Aid

Specialist Practitioner, Domestic Abuse, Berkshire Healthcare NHS Foundation Trust

Domestic Abuse Business Manager - Wokingham Borough Council

Interim Community Safety Partnership Manager, Wokingham Borough Council

All members of the panel were independent of the case and had no prior knowledge or involvement with the victim or the perpetrator.

1.5 The Overview Report author

The independent author of the DHR Overview Report is Steve Appleton. Steve trained as a social worker and specialised in mental health, working as an Approved Social Worker. During that time he worked with victims of domestic abuse as part of his social work practice. He has held operational and strategic development posts in local authorities and the NHS. Before working independently he was a senior manager for an English Strategic Health Authority with particular responsibility for mental health, learning disability, substance misuse and offender health.

Steve is entirely independent and has had no previous involvement with the subjects of the DHR. He has considerable experience in health and social care and has worked with a wide range of NHS organisations, local authorities and third sector agencies. He is a managing director of his own limited company, a specialist health and social care consultancy.

Steve has led reviews into a number of high profile serious untoward incidents particularly in relation to mental health homicide, safeguarding of vulnerable adults, investigations into professional misconduct by staff and has chaired a Serious Case Review into an infant homicide. He has chaired and written a number of DHRs for local authority community safety partnerships across the country, including two previous reviews for this CSP. He has completed the DHR Chair training modules and retains an up to date knowledge of current legislation.

1.6 Subjects of the review

Jane
White British female
Aged 53 at the time of her death
Date of Death: October 2016

Martin
White British male
Aged 55 at time of the offence

1.7 Time Period

The Terms of Reference for the DHR had been developed in advance of the appointment of the independent Chair. However, the Chair did review them and they were discussed and agreed by the full DHR panel at their first meeting.

1.8 Terms of Reference and Key Lines of Enquiry:

- Review the effectiveness of local multi agency policies and procedures.
- Identify learning to inform and improve local inter-agency partnership practice, including recommendations for action.
- Review the effectiveness and appropriateness of communication between partner agencies.
- Establish levels of engagement and support that statutory services offered or provided to the subjects of the review and to consider the quality and effectiveness of any services offered.
- Liaise with surviving family members to determine what level of involvement they wish to have with the DHR process, and how they may wish to contribute to the terms of reference, the review, and the final report.
- Consider engaging with significant others, such as friends of the deceased.
- Consider consultation with the perpetrator.
- Establish the effectiveness and appropriateness of communication between partner agencies.
- Recognise where and if the voluntary sector supported or offered support for the couple and their family reviewing its quality and effectiveness.
- Consider liaison with the perpetrators professional body for insight and any relevant information where necessary.
- Identify good practice and additional learning from this review
- Identify whether the events in October 2016 could potentially have been prevented.

- We will consider the nine protected characteristics of the Equality Act 2010 and determine the relevance in this review, one of which is likely to be age.

- Where the process of DHR identifies any systemic organisational or practice concerns relating to actions required under the Berkshire Safeguarding policies and procedures for Adults or Children, this will be reported to the relevant senior responsible officer of the identified organisation.

1.9 Individual Management Reviews (IMRs)

IMRs were requested from three agencies. The objective of the IMRs which form the basis for the DHR was to provide as accurate as possible an account of what originally transpired in respect of the incident itself and the details of any contact and/or service provision by agencies with both Jane and Martin.

The IMRs were to review and evaluate this thoroughly and, if necessary, identify any improvements for future practice. The IMRs were also to assess the changes that have taken place in service provision during the timescale of the review and consider if changes were required to better meet the needs of individuals at risk of or experiencing domestic abuse.

This Overview Report is based on the IMRs commissioned from local agencies as well as summary reports and scoping information. The IMRs were signed off by a responsible officer in each organisation. The IMRs were considered in depth by the DHR panel, including presentation of them by their authors to the DHR panel. The DHR panel collectively agree and approved the IMRs.

The report's conclusions represent the collective view of the DHR Panel, which has the responsibility, through its representatives and their agencies, for fully implementing the recommendations that arise from the review.

1.10 Diversity

The panel has been mindful of the need to consider and reflect upon the impact, or not, of the cultural background of Jane and Martin and if this played any part in how services responded to their needs.

"The Equality Act 2010 brings together the nine protected characteristics of age, disability, gender reassignment (with a wider definition) marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation."[1]

There are further considerations relating to income and pay gaps, the gender power gap in public sector leadership positions and politics, and the causes and consequences of violence against women and girls, under the Gender Equality Duty.[2]

The nine protected characteristics in the Equality Act were considered by the panel and none was found to have direct relevance to the review.

[1] Paragraph taken from Home Office Domestic Homicide Review Training; Information Sheet 14. P47
[2] Gender Equality Duty 2007. www.equalityhumanrights.com/.../1_overview_of_the_gender_duty

1.11 Confidentiality

The DHR was conducted in private. All documents and information used to inform the review are confidential. The findings of the review should remain confidential until the Community Safety Partnership accepts the Overview Report, Executive Summary and Action Plan. The Overview Report uses pseudonyms for the victim and the perpetrator.

1.12 Involvement with the family

The panel has sought to ensure that the wishes of the surviving family members informed the DHR Terms of Reference and were reflected in the DHR report. The panel has communicated with Jane's brother to inform him of the review.

Jane's brother indicated to his Family Liaison officer that he did not wish to participate in the review. The panel agreed that we would write again to inform him when the review was complete and offer to share a copy of the Overview Report if he wished to have one. Similarly, the Chair wrote to Jane's aunt to advise about the process of the review. She indicated that she did not wish to participate in the review. The Advocacy After Fatal Domestic Abuse (AAFDA) service was discussed with the family.

The Chair wrote to Jane's son, including a copy of the Home Office DHR leaflet, to advise of the review process and seek his view about participation but no response was received. The panel agreed that the draft report would be sent to him for his review and at that stage if he wished to comment or add anything this would be done. At the time of submission, no such response has been received.

In relation to the perpetrator, the independent chair established contact with his solicitors and wrote to them outlining the process of the review and asking them to seek Martin's view about his participation or otherwise in the review.

The solicitors communicated with the perpetrator but received no response from him. They subsequently advised him to contact the Chair of the DHR directly if he wished to be involved in the review.

At the time of writing no communication had been received by the perpetrator. The Chair and the panel therefore reached the conclusion that Martin did not wish to participate in the review. It was agreed that the Chair would keep the perpetrators solicitors advised of the progress of the review and, if requested, would provide a copy of the final Overview Report.

The chair wrote to the perpetrators son to advise of the review process and seek his view about participation. Although in email exchange he indicated he was willing to talk to the Chair, subsequent attempts to contact him were not responded to.

The DHR panel recognises that this means Jane's voice is not as loud in this DHR as would have been hoped for. However, the DHR panel sought at all points during the DHR and within the Overview Report to ensure that her experience has been appropriately highlighted.

1.13 Dissemination

The final Overview Report has been considered by the Wokingham Community Safety Partnership (CSP) and submitted to the Home Office Quality Assurance Panel. The revised report will be disseminated to those organisations that took part in the DHR and other member organisations of the CSP. It will also be published on the CSP website.

Section Two

2.1 Introduction

This overview report is an anthology of information and facts from agencies that had contact with, had provided or were providing support for Jane and Martin. The report examines agency responses to, and support given to Jane and Martin prior to the incident.

Three agencies provided IMRs. They were:

- Berkshire West Clinical Commissioning Group (Primary Care)
- Registered GP – Berkshire East Clinical Commissioning Group (CCG).
- Wokingham Borough Council – Adult Social Care Department

Following detailed scoping work the following organisations made a nil return.

- Berkshire Healthcare NHS Foundation Trust
- Royal Berkshire Hospital NHS Foundation Trust
- Berkshire Women's Aid

Thames Valley Police and South Central Ambulance Service NHS Trust had contact due to their attendance at the incident. Both provided summary reports outlining their involvement.

Domestic Abuse Contact

The DHR has not found any evidence of domestic violence or abuse in this review, either from the IMRs received or the wider scoping work.

None of Jane or Martin's contacts with the agencies prior to the incident were associated with a referral or subsequent assessment and case management associated with domestic abuse or violence. Neither had ever sought any assistance from the police, or any statutory or voluntary sector agency in relation to allegations or incidents of domestic abuse.

2.2 Analysis of Individual Management Reviews

This section of the report analyses the IMRs and other relevant information received by the panel. In doing so it examines how and why the events occurred and analyses the response of services involved with Jane and Martin, including information shared between agencies, why decisions were made and actions taken or not taken. Any issues or concerns identified are a reflection of the evidence made available.

The findings of the review are set in the context of any internal and external factors that were impacting on delivery of services and professional practice during the period covered by the review.

2.2.1 NHS – General Practice (Martin's GP)

Martin was registered with a surgery in West Berkshire. The IMR conducted by the CCG had access to GP records covering the period May 2013 to October 2016. Martin accessed GP consultation as and when needed. The GP recalls no concerns about Martin's presentations at the surgery.

The GP was aware of Martin being a carer to his previous partner, who died following breast cancer in spring 2015.

During 2015 the GP saw Martin in relation to a knee injury, sustained in the course of his work.

The IMR refers to Martin experiencing financial worries relating to his business. Martin was seen by his GP shortly before the incident. During this consultation he reported experiencing anxiety and sleeplessness as a result of financial problems. His business had recently lost a large contract and he had had to make redundancies.

When questioned by his GP, the IMR states that Martin described having had some suicidal thoughts. There is no description about what further questions the GP asked about the nature of these suicidal thoughts, whether any recognised risk assessment tool relating to suicide and suicidal intent was used. Nor is there any evidence to indicate that any form of assessment tool relating to depression was used during the consultation.

The IMR states that the GP had no concerns that Martin would harm himself or others. The GP stated that he intended to explore the stress factors Martin was experiencing at the planned follow-up appointment.

The GP prescribed medication called Sertraline and Zolpidem. Sertraline is an antidepressant in a group of drugs called selective serotonin reuptake inhibitors (SSRIs). Zolpidem is a sedative medication that is often used to treat insomnia. Both were prescribed for short-term use and the GP had arranged to review Martin a week after the consultation on 25 September 2016.

The IMR includes some further history relating to Martin and his previous partner, who died as a consequence of breast cancer in April 2015.

The IMR makes clear there were no concerns and no evidence of domestic abuse within Martin's relationship with his previous partner and no other indicators in subsequent presentations by Martin to his GP. The GP was 'domestic abuse aware' and had attended relevant, locally provided training.

The GP did not feel that Martin required a referral to the Common Point of Entry for mental health services. The GP believed that the conversation about suicidal thoughts was more a demonstration of desperation about the financial difficulties that Martin was experiencing.

Lessons learnt

The GP appears to have acted proportionately and sensitively to Martin's presentation. The interactions between Martin and the GP were appropriate, but the absence of the use of a recognised tool for assessing suicidal intent and risk relating to this highlights the variance in practice within the GP community.

The use of such a tool, while not affecting the outcome in this case, would have provided a clearer and more evidenced basis for the GPs clinical decision making. This is not to call into questions the GP's clinical judgment. It is about knowledge and use of appropriate tools to assist that clinical decision making and providing a clear written record of the rationale for those decisions.

The IMR makes two recommendations which can be found in Section Four.

2.2.2 NHS Berkshire East CCG General Practice (Jane's GP)

Jane was registered with a GP practice in East Berkshire. Jane's named GP at the time of the incident has now retired and so the IMR was provided by the lead GP at the practice, Dr. J. In preparing the IMR, Dr. J. had access to Jane's medical records and also discussed the contact between Jane and the surgery with all the doctors working at the practice.

Jane was seen by her named GP, Dr. M, and two other doctors working at the practice prior to her death, Dr. R. who is also now retired and Dr. D. who still works at the practice on a part-time basis. Dr. J. only met Jane once, in December 2013.

In February 2014 Jane saw Dr. D. for an asthma review. There was then a gap of 11 months before the next contact.

In January 2015 Jane saw Dr R. in relation to back pain that she had been experiencing. She was given advice about back exercise and invited to return if the pain worsened.

The next contact the surgery made with Jane was in February 2016 when a telephone consultation was set up with the Nurse Practitioner. However, Jane had not been available and a message had been left on her answering machine to contact the surgery about her smoking status and also to advise her about a flu jab and that she needed an up-to-date blood pressure check.

In March 2016 Jane was seen by her registered doctor, Dr. M. This was for a medication review and a breast check as she had been diagnosed with breast cancer in April 2006. It was found that the chest examination was normal, as was the breast examination. Blood pressure was normal. There was a discussion around the possibility of stopping Tamoxifen medication within 12 months. A note was also made that she had developed osteoarthritis at the tip of her hands and feet. Dr. M had advised her on how to cope with these.

In August 2016 Jane saw Dr. M. about stopping the Tamoxifen. Jane also saw one of the Practice Nurses for a routine screening test that month. There were no unusual findings, no comments were added to her records about any concerns that she had on examination.

In September 2016, Jane was contacted by the Nurse Practitioner as she had requested a telephone triage consultation. It was noted that Jane had been on annual leave for the previous two weeks and she had a viral sore throat, sore eyes and aching joints and needed a note so that she could retrieve her holidays from work. She was advised to discuss this with a GP.

Later that same day Dr. D. telephoned her to enquire some more about the details. It was found that Jane had been off work since September 2016 and was due to go back in October. Jane informed Dr. D. that she could reclaim the annual leave if she had been unwell, but this required a sick note as evidence of the illness. Jane was still feeling unwell with an upper respiratory tract infection, sore throat and headaches.

Dr. D. had felt that she needed to come in for an examination, and on the same day Jane came in to see her. A medical sick note was issued for an upper respiratory tract infection viral illness and the duration stated would be for a week and she was advised to come back should the symptoms worsen.

In October 2016, the Surgery received a request from the Police to release Jane's medical records. This was the first time they were aware that Jane had died. Medical records were copied and passed on to Dr. M. to check through before they were sent across to the Police as they had requested.

Lessons learnt

The contact between Jane and the GP surgery appears to have been appropriate and professional throughout. The contacts between them were for mainly minor issues, standard follow-up and medication reviews or routine tests.

The IMR finds no evidence that domestic abuse or violence was present in Jane's household. It specifically reports that there were certainly never any physical signs that would have raised concerns or led to further questioning by the GPs at the practice. Although routine enquiry did not take place, there was nothing in Jane's presentation to the GP's that would have stimulated any form of enquiry about domestic abuse.

The practice responded swiftly and appropriately to requests for appointments and in the matter of requesting a sick note, proactively invited Jane to attend the surgery so that a face-to-face consultation and discussion could take place.

The IMR expresses disappointment that the surgery was not made aware of Jane's death until two days after the event.

From the IMR the panel concludes that the practice provided a high standard of care to Jane and that there are no gaps in the quality of their practice.

The IMR did not make any recommendations.

2.2.3 Wokingham Borough Council Adult Social Care

Wokingham Borough Council (WBC) Adult Social Care conducted an IMR as they wished to use the process to establish any involvement with Jane or Martin. In doing so the IMR author reviewed the Framework [3]system and records of other council teams including housing needs and commissioned services for drug and alcohol misuse and domestic violence.

The services of Wokingham Borough Council had no contact with Jane.

The services of Wokingham Borough Council had no direct contact with Martin, although he was named on the records of his deceased former partner, who died in hospital as a result of cancer.

On this basis, WBC has declared a nil return.

2.2.4 Scoping of other agency engagement

Berkshire Healthcare NHS Foundation Trust and Berkshire Women's Aid all conducted scoping work that established their organisations had no contact with either Jane or Martin.

The Royal Berkshire NHS Foundation Trust scoping identified that their contact with Jane fell outside the timeframe for the DHR and that there had been no contact with Martin.

On that basis these organisations did not submit IMRs.

[3] WBCs electronic data base for adult care services

2.2.5 Chronology of events

Date	Event	Outcome	Source
5th January 2016	Martin attended GP surgery to discuss suicidal thoughts. Following a 1:1 discussion, this was felt to be linked to worries about his financial situation and an appointment discussed for a follow-on appointment post one week.		Wokingham Clinical Commissioning Group (CCG) IMR
9th February 2016	Routine telephone consultation was set up with Nurse Practitioner with Jane.		GP Surgery IMR
11th March 2016	Jane was seen by her registered doctor for medication review and a routine check linked to a previous condition.	Discussion on medication and advice, checks completed and discussion around new condition.	GP Surgery IMR
11th August 2016	Jane attended surgery again to agree medication change.	Discussion held on medication change.	GP Surgery IMR
15th August 2016	Jane attended for a routine screening test.	Procedure undertaken	GP Surgery IMR
26th September 2016	Martin attended GP surgery and disclosed concerns linked to financial problems, sleep issues and suicidal thoughts. Follow on appointment to be undertaken in 1 week.	Medication prescribed and physical examination undertaken.	Wokingham Clinical Commissioning Group (CCG) IMR
28th September 2016	Jane was contacted by Nurse Practitioner following request by Jane for a telephone triage consultation and sickness note. GP spoke to Jane on the telephone and as a result requested Jane attend the surgery which she did that day.	Telephone appointment In person consultation	GP Surgery IMR
2nd October 2016 23.27hrs	Martin rang 999 from his home address and stated that he had just stabbed and killed his girlfriend, Jane. He then stated that he was going to stab himself. Officers attended and found Jane deceased and Martin with stab wounds to his chest/abdomen. When officers arrived, Martin intimated that financial difficulties, and the discovery that Jane had allegedly been having an affair, had triggered his actions.	Martin was taken to hospital and underwent live saving treatment	Thames Valley Police Individual Management Review (IMR) for Domestic Homicide Review (DHR)

Section Three

3.1 Conclusions

This section sets out the conclusions of the DHR panel, having analysed and considered the information contained in the IMRs within the framework of the Terms of Reference for the review. The chair of the DHR is satisfied that the review has:

- Been conducted according to best practice, with effective analysis and conclusions of the information related to the case.
- Established what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support vulnerable people and victims of domestic violence.
- Identified 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.
- Reached conclusions that will inform recommendations that will enable the application of these lessons to service responses including changes to policies and procedures as appropriate; and
- Will assist in preventing domestic violence homicide and improve service responses for all vulnerable people and domestic violence victims through improved intra and inter-agency working.

The conclusions presented in this section are based on the evidence and information contained in the IMRs and draws them together to present an overall set of conclusions that can be drawn about the case.

3.1.1

Jane had limited contact with statutory services and this was confined to routine consultations with her GP and the primary care team at her GP practice. These contacts were appropriate and professional. The panel concludes that the findings of the IMR are accurate and that no evidence of concerns from Jane were present and that there was no indication that anything in her relationship or wider home life was of concern.

The perpetrator in this case similarly had limited contact with statutory services and these were confined to contact with his GP and the primary care team at his GP practice.

In reviewing the contact of the GP, the panel concludes that their contact with Martin was professional and was of an appropriate standard. Those who had contact with Martin paid due and proper regard to his circumstances and had put in place a suitable regime of medication to address his low mood. The panel concludes that the decision not to refer to specialist mental health services was appropriate given his presentation at the time.

The panel concludes that the use of a specific tool for assessing suicidal ideation could have helped the GP establish the actual nature of Martin's mood and potential for acting on suicidal thoughts. However, the assessment and enquiry undertaken by the GP was appropriate and their clinical judgment was correct. The panel agrees with the recommendation made in the IMR that the CCG draw upon good practice from elsewhere and put in place a risk assessment tool to support GPs in assessing suicidality.

The panel concludes that the systems, policies and processes of the NHS and WBC did not impact directly on the incident itself. The limited contact between NHS primary care services was appropriate and no other statutory organisations had any contact with either the victim or the perpetrator.

This incident occurred without any prior indication that it was likely. The risks surrounding the perpetrator were all concerned with his own safety and welfare and there was nothing that suggested that he was a risk either to Jane or to others.

Section Four
Recommendations

4.1 DHR panel recommendations

Based on the conclusions from this review the DHR panel has agreed that there are no recommendations to be made in this case above the two made in the Berkshire West Clinical Commissioning Group IMR.

4.2 Recommendations made in the individual IMRs

Only the Berkshire West CCG (General Practice) IMR made recommendations:

- CCGs to consider producing and offering primary care a general risk assessment tool with a summary signposting section.

- Share good practice from other surgeries that have developed carers templates with a risk assessment across primary care to support the current embedded practice where GP flag records for carers.

[i]Pseudonyms used to protect the identity of the party involved.
[ii] Pseudonym used to protect the identify of the party involved.