Approved by the Home Office
November 2015

Safer Somerset Partnership

Feel Safe, Be Safe

Domestic Homicide Review
Overview Report

Into the death of Mrs C
30th November 2013

The Review Panel send their condolences
To the family of Mrs C

B Higgs

Independent Panel Chair and Author

Preface

This Domestic Homicide Review (DHR) was conducted to explore the circumstances surrounding the death of Mrs C

The Independent panel chair would like to thank all those that gave their time to contribute to the report

Contents

Please note that the subjects of this report have been anonymised throughout.

1.0 Introduction

This Domestic Homicide Review was commissioned by the Safer Somerset Partnership following the tragic death of Mrs C 30th November 2013.

The Review has been carried out in accordance with the Home Office guidance and section 9 (3) of the Domestic Violence Crime and Victims Act 2004 and the expectations of the Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (revised August 2013). The overview report has been prepared in accordance with Home Office Guidelines (January 2014).

This review was carried out under the auspices of Section 37 of the DHR Guidelines that states that the CSP should consider conducting a DHR where the victim committed suicide and the circumstances give rise to concern:

Specific aims of the terms of reference required that the overview report should:

- Summarise concisely the relevant chronology of events including the actions of all the involved agencies;

- Analyse and comment on the appropriateness of actions taken;

- Make recommendations, which if implemented, will better safeguard people experiencing domestic abuse, particularly those who are older and anyone who may also experience mental health problems, or a disability or other chronic ill health

Full Terms of Reference and Key Issues – p.10

1. Introduction

1.1 Case Summary

At approximately 7.50am on Saturday 30th November 2013 the Ambulance Service contacted the police in respect of a call to an address in Somerset.

Mrs C had been pronounced dead by the Ambulance team at 07.48. Mrs C had been found in her bed cold and unresponsive by her husband. The couple had argued the night before. Mr C disclosed that Mrs C had hit him and threatened to take her own life, as a result he had slept in the living room. He showed police injuries he stated were sustained during that incident.

A half bottle of wine was by the bed and note suggestive of suicide was found at the scene.

The couple had been married for five years during which time the relationship could be described as volatile featuring arguments and injuries. The marriage also featured long absences. Mr C was in the Royal Navy and often at sea. As the marriage difficulties escalated the couple also separated for over a year. Both Mr and Mrs C claim DVA took place in the relationship.

This was Mrs C's second marriage. She had two children by her first marriage and the children remained with their father. This was Mr C's second marriage but third relationship. He has one child by each of his former partners both retained custody of the children.

1.2 Review Panel Members

Review Panel Chair and Author Senior Commissioning Officer (Interpersonal Violence) Adult & Health Commissioning Somerset County Council	B Higgs S Harris
Detective Chief Inspector Avon & Somerset Constabulary Public Protection Unit	Insp. C Howard
Senior Nurse, Safeguarding Somerset Clinical Commissioning Group	G Munro
Designated Nurse Turning Point/Somerset Drug & Alcohol Service Acting Deputy Operational Manager	A Cole

The panel met on:

10th March 2014
28th April 2014
23rd June 2014 (postponed to 10th July)

E-mail and telephone contacts were made between meetings.

1.3 Agencies Contacted

The following Somerset agencies were asked by the advisory group to search their files for known contacts with the victim or perpetrators

Avon & Somerset Constabulary
Avon & Somerset Probation Trust
Chapter 1
IDVA/Bournemouth Churches Housing Association
Mendip District Council
NHS Foundation Trust (Yeovil District Hospital)
SCC Children's Social Care
Sedgemoor District Council
Somerset Clinical Commissioning Group
Somerset Partnership NHS Foundation Trust
Somerset Safeguarding Adults Board
Somerset Adult Social Care Foundation Trust
South Somerset District Council
Taunton & Somerset NHS Foundation Trust (Musgrove Hospital)
Taunton Deane Borough Council
Turning Point/Somerset Drug & Alcohol Service
Victim Support
West Somerset Council

Enquiries were also made In North Wales, Yorkshire and Hampshire:

North Wales Constabulary
North Wales (Wrexham) Community Safety Partnership
NHS Wales
Hampshire Constabulary
North Yorkshire Constabulary
Fareham and Gosport Community Safety Partnership
Royal Navy

Additional information supplied by:
Welsh Women's Aid Wrexham
Victim Support Hampshire

1.4 Review Panel Chair and Overview Report Author

B Higgs is not and has never been an employee of any of the agencies taking part in the review. B Higgs' knowledge of a wide range of social issues was gained from seven years tenure as a Citizens Advice Bureau Manager. Advice services were also delivered to a women's DVA refuge and a Category 'C' HMP. B Higgs has an MA in Criminology & Criminal Justice and is currently engaged in doctoral research at the Institute of Criminal Justice Studies, Portsmouth University.

1.5 IMR Authors

Avon & Somerset Constabulary	Insp. L Jones
Turning Point/ SDAS	A Cole
Somerset Clinical Commissioning Group	K Gates
NHS Foundation Trust (Yeovil District Hospital)	P Wilcox

Each IMR author fulfilled the criteria to conduct an IMR within their organisation. IMR authoring briefings were made available to authors.

1.6 Parallel Review: Coroner

1.7 Timescale

The Chair of the SSP was notified by the Avon & Somerset Police Public Protection Unit of Mrs C's death by letter dated December 5th 2013.

The SSP advisory group met on January 6th 2013 where it was agreed that the Partnership Chair would be advised to commission a DHR in accordance with the relevant legislation and guidance.

Consideration was given to the revised Home Office Multi Agency Statutory Guidance for the Conduct of DHRs in determining who should be appointed as the Independent Panel Chair. The impartiality, skills and expertise of the individual was prioritised. The SSP appointed B Higgs as Independent Panel Review Chair and report author in January 2014.

10th February	First Review Panel Meeting
25th April	IMR submission
6th June	Final review panel meeting

The schedule of the review was extended as Mr C came to the process in its late stages to contribute. His information led to further enquiries.

1.8 Circumstances Leading to the Review

The SSP advisory group agreed that the death of Mrs C fell within the definition included in the Multi–Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (revised August 2013) criteria as set out below:

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) a person to whom he/she was related or with home he/she was or had been in an intimated personal relationship

(b) a member of the same household as himself, held with a view to identifying the reasons to be learnt from the death

"any incident or pattern or incident 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."[1]

1.9 Scope

The DHR advisory group decided that there were sufficient complexities in Mrs C's background to suggest that a review in accordance with S.37 of the Home Office DHR guidelines would be recommended to the Partnership Chair. The preliminary information known to the advisory group at the time of the decision included the following:

[1] Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews. Revised – applicable to all notifications made from and including 1 August 2013 Paragraph 12

- Mr and Mrs C both had children from previous relationships.

- Both Mr and Mrs C had assaulted each other during the course of the relationship. That Mr C verbally abused Mrs C.

- That Mrs C had a history of 'low mood' and a long history of prescribed anti-depressant medication.

- That Mrs C had a history of alcohol misuse.

There were considerable gaps in knowledge at the outset partly due to the fact that the couple had lived in three areas, North Wales, Hampshire and Somerset. It was agreed that the Terms of Reference would include the involvement of these areas to complete the background and agency involvement that the couple experienced.

To review events for a minimum of 6 years preceding the domestic abuse related death of Mrs C on 30th November 2013, unless it became apparent that the timescale in relation to some aspect of the review should be extended.

1.10 Terms of Reference

The purpose of the Domestic Homicide Review is to:

Ensure the review is conducted according to best practice, with effective analysis and conclusions of the information related to the case.

Establish what lessons are to be learned from the case about the way in which local professionals and organisation work individually and together to safeguard and support victims of domestic violence including their dependent children.

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 homicide and improve service responses for all domestic abuse victims and their children through improved intra and inter-agency working.[2]

Specific aims of this review were to:

- summarises concisely the relevant chronology of events including the actions of all the involved agencies;

- analyse and comment on the appropriateness of actions

[2] Paragraph 3.3 Home Office Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews

taken;

- make recommendations which, if implemented, will better safeguard people experiencing domestic abuse, particularly those who are older and anyone who may also experience mental health problems or a disability or other chronic ill-health

The review considered the following questions:

- To establish a profile of Mrs C and her familial and close relationships.
- To establish if family, friends, colleagues, or employer, wanted to participate in the review. If so, to find out a) if they were aware of any abusive behaviour prior to her death and b) if there were indications that Mrs C may take her own life
- Whether in relation to family members or colleagues, where there any barriers to reporting suspected abuse. The extent of Mrs C's contact with any specialist domestic abuse agency or service in the County. To consider if there were any warning signs which were not acted upon
- Could improvement of the following have led to a different outcome for Mrs C;-

a) Communication and information sharing between services.

b) Communication within services.

c) Communication to the general public and non-specialist services about available specialist services related to domestic abuse or violence.

- Whether any organisational policy training or awareness raising requirements are identified to ensure a greater knowledge and understanding of domestic abuse processes and/or services.
- Whether the work undertaken by the services in this case is consistent with each organisation's own:
- Professional Standards
- Domestic Abuse policy, procedure, protocols
- Compliant with its own general protocols, guidelines, policies and procedures

- Whether practices by all agencies was sensitive to the characteristics of the Equality Act 2010, including age, disability, gender reassignment, marriage/civil partnership, pregnancy and maternity, race, sex, sexual orientation, religious belief and specialist needs on behalf of the subjects were properly considered and appropriate actions taken and recorded

- Any other information that becomes relevant during the conduct of the review.

1.11 Key Issues

In summary the key issues to consider were:

- How far and to what extent did the circumstances of Mrs C's marital relationship and living arrangements contribute to her death

- How far and to what extent did the circumstances of Mrs C's family life contribute to her general well-being

- To establish what if any specialist DVA support was offered to either Mr or Mrs C

- Whether the fact that Mr C was military personnel had any bearing on the accessibility to specialist services

1.12 Methodology

The following agencies were asked to undertake IMR's

Avon & Somerset Constabulary
Turning Point/Somerset Drug and Alcohol Service
Somerset Clinical Commissioning Group (GP)

The purpose of the IMRs is to:

- Provide information that will contribute to an integrated chronology of agency contacts by Mr and Mrs C

- Search records outside the identified time periods to ensure no relevant information was omitted

- Provide an IMR: identifying the facts of their involvement with those identified, critically analysing the service they provided in line with the specific terms of reference; identifying any recommendations for practice or policy in relation to their agency.

- It was also specifically requested that good practice was highlighted

The overriding purpose of an IMR is to give an as accurate as possible account of what originally transpired within the agency response, to evaluate it fairly, and if necessary to identify any improvements for future practice. The IMR should also propose agency specific solutions which are likely to provide a more effective response to a similar situation in the future.

As the review progressed considerable discussion took place concerning the method that Avon and Somerset Constabulary should adopt to conduct an IMR involving multiple police forces. One school of thought felt that the police should be considered as one agency whereby each force should provide their chronological information to the 'host' force, and that a single IMR should be written to provide information and analysis based on accepted national guidelines for policies and procedures.

A second view was that the 'host' force, in this case Avon and Somerset Constabulary were not best placed to critically assess and comment on the quality or practice of other forces without the knowledge of their individual policies and procedures, and those individual IMRs should be produced by each force. This approach would undoubtedly create resourcing implications for each force to research and analyse all their information and produce an IMR. This would also necessitate either the host force, or the Overview Report author considerable extra work to chronologically order each's information to provide an overview of all police interactions with those subject to the DHR.

There were strong arguments for both approaches and in this case, it was agreed that the IMR provided would simply report but not analyse the actions of other police forces.

The DHR Panel members are asked to complete the online DHR training before attending the panel. IMR authors are invited to briefings to assist the understanding of the quality and content required of an IMR. In this case one briefing was offered. Individual agency IMR's should be quality assured by the DHR panel member before being forwarded to the Independent Chair of the Panel. The IMR must be signed off by a responsible officer in the organisation who will also maintain the strategic ownership of the individual agency action plan.

Family & Friends

The Panel Chair initiated contact with Mr C. The DHR process was explained to establish if he wanted to contribute. Mr C and the panel chair met for one interview toward the end of the DHR preparation. This led to new information and the panel chair made enquiries to trace Mrs C's family in Wales. Her former husband and children had moved. Mrs C's mother was traced and contributed via telephone interview. Former colleagues and her employer were contacted but declined to contribute.

Voluntary Sector

Mrs C made contact with Welsh Women's Aid who provided a report.

Victim Support provided information regarding the assistance Mr & Mrs C received following an assault on them both in October 2008.

Publications

The review panel chair referred to the following publications:

Tackling Domestic Violence: theories, policies and practice (Harne, L., & Radford, J., 2008 OUP)
Policing Domestic Violence (Richards, L., Letchford, S., Stratton, S., 2008, OUP)
Coercive Control: How Men Entrap Women in Personal Life (Stark, E., 2009 OUP)
Why Does He Do That? (Bancroft, L., 2002, The Berkley Publishing Group, Penguin, London)

1.13 Publication and Dissemination

The content of the Overview Report and Executive Summary have been anonymised in order to protect the identity of the victims, perpetrator, relevant family members, staff and others, and in order to comply with the Data Protection Act 1998. An executive summary has been produced in a form suitable for publication with any redaction before publication with the agreement of the review panel and the Safer Somerset Partnership.

The report has been shared with the contributing organisations. In order to secure agreement, pre-publication drafts of this overview report were seen by the membership of the review panel, commissioning officers and the Chair of the Safer Somerset Partnership.

It has also been shared with the Home Office Quality Assurance Group[3] and the Coroner's office.

This overview report and/or executive summary will be made public and the recommendations will be acted upon by all agencies, in order to ensure that the lessons of the review are learned.

[3] Home Office quality Assurance Letter Appendix A. SSP response Appendix B

2.0 Organisational Context

2.1 Context

This section contextualises events alongside relevant local and national data, policy procedures and guidance.

2.2 Statistics

The Avon & Somerset Constabulary force area encompasses the cities of Bristol and Bath as well as the rural areas of North Somerset, South Gloucestershire and the County of Somerset. Population 1,308,608.

Overall crime in the Avon & Somerset force area is falling, reflecting trends broadly in line with the national average[4].

Year	Crimes per 1,000 population
2010-11	71.44
2011-12	65.31
2012-13	59.94

The repeat victimisation rate for domestic abuse remains below the target set by the Home Office. Levels of domestic abuse related incidents reported to the police have remained relatively stable. The annual rise may be accounted for by increased awareness and reporting to police.

In 2014 Her Majesty's Inspectorate of Constabulary's (HMIC) conducted research and released the report *Avon & Somerset Constabulary's approach to tackling domestic abuse.*[5] The report noted that for the 12 months to end of August 2013 domestic abuse accounted for:

8%	of all recorded crime
21%	of all assaults with intent to cause serious harm
36%	of all assaults with injury
57%	of all harassment offences
13%	of all sexual offences

[4] http://www.police.uk/avon-and-somerset/FC002/performance/force-performance/
[5] www.hmic.gov.uk

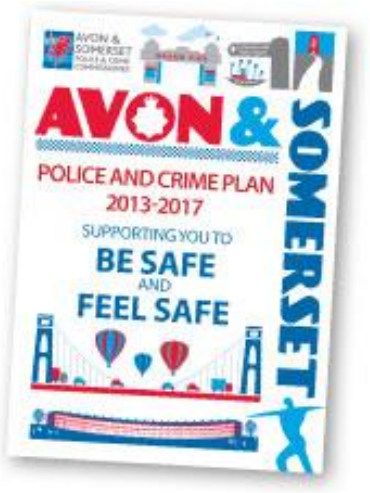
On, 31 August 2013 Avon and Somerset had 14,840 active domestic abuse cases; 5% were high risk, 24% were medium risk, and 71% were standard risk. Arrests. [6]

MARAC data (rolling 12 months to January 2012)[7]

	Somerset Total
Number of cases	513
Number of repeats	123
% repeat referrals	23.15%

2.3 Police and Crime Commissioner

The Police & Crime Commissioner for Avon & Somerset has prioritised domestic abuse in the Police and Crime Plan 2014-2017



[8]

"*Domestic abuse is an inexcusable form of cruelty and will not be tolerated in Avon and Somerset. Tackling violence against women and children is one of my priorities and domestic abuse is taken very seriously across Avon and Somerset. I want all victims to know that there is help available - from the Police and other agencies - and that no one deserves to suffer in silence.*"

The PCC actively supports initiatives such as the *This is Not an Excuse* campaign to raise public awareness and encourage reporting to the police.

2.4 Safer Somerset Partnership

The SSP is made up of organisations who are required under statute to work together to formulate strategies for tackling crime, disorder, antisocial

[6] Taken from data submitted to the Home Office by the police and based upon the forces' own definition of calls for assistance and domestic abuse and force's use of domestic abuse markers on IT systems.

[7] http://www.somersetintelligence.org.uk/domestic-violence-cyp.html

[8] http://www.avonandsomerset-pcc.gov.uk/Your-PCC/Police-and-Crime-Plan.aspx

behaviour and reduce re-offending in Somerset.

The SSP identified its priorities in its Partnership plan September 2013- March 2015.

A stated priority within the Safer Somerset Partnership Plan for 2013-15 is:

Protecting Vulnerable People against violence, Harm and Victimisation
Lead Agency : Somerset County Council

Action:

- *Work with Avon and Somerset Violence against Women and Girls Strategic group to improve strategic accountability/oversight of the Specialist Domestic Violence Courts to help them continue to operate effectively and improve victim confidence/safety.*

On the 1st August 2013 the SSP re-visited and approved the Somerset Interpersonal Violence Strategy 2011-14.

"We aim to lead a co-ordinated effort to both prevent and reduce incidences of gender-based interpersonal violence in Somerset. Everyone can contribute to raise awareness of not just the effects that this has, but to challenge those who condone it and help protect those affected"[9]

3.0 The Facts

3.1 Mrs C – Victim Profile

Originally from the North Wales area Mrs C was 42 at the time of her death. She was brought up by her mother and father, she has a brother.

Mrs C is described as bright, fun and intelligent, but in the latter years was said to be 'troubled' although the reasons why could not be defined. She was said to have always had a fiery temper and could hold her own in most situations.

From her medical records it is known that Mrs C was prescribed anti-depressants from 1997. It is not clear what form the depression took, the underlying reasons for it nor why the prescription was continued for fifteen years. It is known that her brother also suffers from long term depression.

She married Mr M and had two children, a son born in 1995 and a daughter born in 2001. Her son was diagnosed with mild cerebral palsy as a toddler.
Mrs C and her first husband divorced although it has not been possible to

[9] http://www.somerset.gov.uk/EasySiteWeb/GatewayLink.aspx?alId=41390

establish when. Mr M retained custody of the children from the outset as Mrs C at the time couldn't settle and didn't know what direction she wanted to take. Relations with Mr M remained amicable.

Mrs C worked for NACRO the crime reduction charity and was assaulted by a client in February 2004 resulting in black eye, bruising and swollen face.

In May 2007 Mrs C was cautioned for Section 47 actual bodily harm regarding an incident where she stabbed her then partner Mr K. An analysis of this incident appears later.

In the same year Mrs C met Mr C via an online dating service. The couple met in November and got on well. In January Mr C went to sea with the Royal Navy for a 6 month tour. On his return the couple married in August 2008.

3.2 Mr C – Partner Profile

Mr C was aged 42 at the time of his wife's death.

Mr C has a former wife and a former partner; he has a child with each.

Mr C met and married his first wife as a young man. During the marriage he joined the Royal Navy and was away for long periods of time. The couple had a son. While Mr C was absent on duty Mrs C (1) bought a house in Hampshire which Mr C never took to, he identifies this as the start of the marriage decline. Relations were initially acrimonious particularly over access to his son. Relations improved and are now good.

Mr C had a relationship with AD who was also in the Navy. They had a daughter. Mr C claims that there was heavy drinking in the relationship particularly by his partner. In December 2006 AD claimed that she had been assaulted. The police attended and bruising was witnessed. Mr C attended his GP and discussed the fact that her parents were accusing him of being violent. Which he denied. The couple argued and AD said she had taken pills when she had not. Although a wedding was planned for 7th May the relationship broke down. There were initial issues over access to the daughter of this relationship but these were resolved and relations are now good.

Mr C met Mrs C (2) in November 2007 via an internet site. Mr C went to sea two months later. The couple married in August 2008. Mr C says with hindsight this was too quick and in many respects he didn't know the woman he married. After marriage the relationship became volatile and occasionally violent.

In October 2008 the couple were subject to an assault and robbery by unknown youths.

Mr C was supported throughout his Royal Naval career by medical and welfare services.

In October 2012 Mr C left the Royal Navy and began work for a major aviation manufacturer.

3.3 Narrative Chronology

Introduction

In the period examined both Mr & Mrs C were in contact with a range of agencies. There are reports of incidents in Somerset, Hampshire and North Wales and one report from Yorkshire. This narrative chronology focusses on contact with agencies that relates to either DVA, threats of suicide or criminal activity.

This chronology includes information taken from official records including the Royal Navy, N Wales, Avon & Somerset and Yorkshire police forces, Yeovil District Hospital, GP practice, Victim support and Welsh Women's Aid. Interviews with Mr P and Mrs D the victim's mother provide important additional information. Where there are discrepancies or contradictions in accounts these have been noted.

2007

Jan-December

Mr C was serving in the Royal Navy and was based in Hampshire. His partner was AD by whom he had a daughter. Royal Navy records report that the relationship was not going well; there had been a violent incident in 2006. Mr C was drinking, not sleeping; he was offered and took up psychiatric support. He was also seeing Relate 1:1. He left to go to sea in June. Relationship and childcare issues were unresolved. There are no further reports.

19th May

Police records state Mrs C had been out with her then partner Mr K in York. There was an argument and Mrs C stabbed him causing a 2 inch wound to the bottom. She was arrested and cautioned for Section 47 Actual Bodily Harm*.

21st May

Mrs C attended her GP and presented with bruising on upper arm, chest, forearm and shoulder. Assaulted by then partner Mr K.

*Police Analysis**

The file was reviewed and found to be missing a medical report to confirm the severity of the injury. Witness accounts reveal that at one point the victim appeared to be unconscious and bleeding heavily. It is not clear why a caution was authorised as based on the file evidence this incident constituted Grievous

Bodily Harm as covered by the Offences Against the Person Act and would at least be considered as a Section 20 wounding (GBH) offence or a section 18 GBH with intent, both are more serious and routinely heard at Crown Court and can carry a sentence up to life imprisonment.

In this case the victim provided a statement and said he would not support a police prosecution admitting he encouraged the suspect to stab him. Mrs C administered first aid and called for help. She made disclosures to the police admitting a version of events in interview.

Faced with an incident of this nature today this Force (Avon & Somerset) would seek a charge decision from the Crown Prosecution Service and if necessary request a victimless prosecution. At the point of incident a DASH risk assessment would be carried out and if the risk was high and the evidential base sufficient then a referral to MARAC would be made. It is not clear what processes were in place in North Yorkshire at the time.

October/November 2007

Mr and Mrs C met online.

<u>2008</u>

January 2008

Mr C went to sea until June.

August 2008

Mr & Mrs C married and lived in Hampshire.

October 2008

Mr & Mrs C were victims of an assault, robbery and sexual assault by 4 youths in Hampshire. Mrs C sustained the most serious injuries. Mr C claims they were walking home from a pub when a youth bumped into Mrs C on a bicycle. Mrs C said something to cause the youth to come back and grab her. Meanwhile three other youths had come up behind Mr C knocked him out. They repeatedly stamped on his head and made Mrs C watch. Mr C sustained severe bruising to both eyes She was then assaulted causing a fractured jaw and eye socket for which she later had reconstructive surgery. There was then an attempted sexual assault on Mrs C. The couple left the scene separately and both made their way to Mr C's father's house from where an ambulance was called. Mr C claims that the incident was avoidable had Mrs C not said whatever she did to provoke the youths.

Police records state the assailants were never found. There was insufficient evidence to support the claims of robbery and sexual assault. The couple were asked by police if they had been fighting each other. They both categorically denied this suggestion.

December 2008

17th December

The police were called to a domestic incident where both Mr and Mrs C had consumed alcohol. Mrs C became volatile, knocked over the Christmas tree, trodden all over the wrapped Christmas presents and then left. Mr C said he had to defend himself by pushing her away. As a result she banged her head. Mrs C was traced to her ex-husband and children's address in North Wales where she was safe and well.

22nd December

GP records attendance by Mrs C with bruising across both eyes and swelling to her left cheek. Mrs P said she fell accidentally. An x-ray was arranged. It is likely that these injuries were as a result of the incident on 17th December.

2009

January 2009

RN records state the couple were significantly affected by the assault on them in October 2008 and agreed to counselling. Mr C took a different Royal Naval assignment to facilitate treatment.

July 2009

Hampshire police record a domestic incident. Mr & Mrs C had both consumed alcohol. The argument related to the incident at Christmas last year, it turned physical and both sustained minor injuries. Both were arrested for assault, both refused to prosecute the other. Risk assessed as standard. Police Public Protection Unit (PPU) required to follow up reference support.

August 2009

The couple separated and Mrs C returned to Wales.

October 2009

Mrs C was arrested and charged with drinking and driving. Convicted in Wrexham.

2010

April 2010

Police reports that they are called to an address in Wales. Mrs C had a cottage for about 6 months. Although they had split in August 2009 Mr C visited and

stayed from time to time. They had argued about Mr C's son staying with them. Mrs C gave up the cottage to go and live with her parents. Her father was terminally ill and died that month. Mr C returned to Hampshire.

Police reports say they were called on 13th April to another incident between the couple where Mr C had gone to collect furniture and belongings.

No risk indicator completed. The matter was referred to social services for information only.

14th May 2010

A Hampshire police report from Mr C about continuous texting from Mrs C who is living in N. Wales. Mr C admitted texting back. Considered as low risk. Advice given.

12th July 2010

Mrs C requested to speak to a DV officer in Wales. She reported physical, emotional and mental domestic incidents against her husband Mr C. She was referring specifically to an incident on 10th July when they were out drinking. He accused her of flirting with someone and stormed off. They both arrived back at their flat and he started shouting at her and then punched her several times to the face and body. She said that she punched him back in self-defence and then he tried to strangle her. She says the Military Police would not do anything and asked her to leave the site. She says she had reported the abuse to her GP and she was not receiving any medication. The PC noted the injuries and took Mrs C to hospital. She said she was frightened. She also said she had seen a solicitor to start divorce proceedings.

The Military Police spoke to Mr C but no action was taken.

The emergency department report from Wrexham hospital is consistent with the above. On examination Mrs C had bruising to the left side of her face, left neck, upper right arm and left shoulder. She was given an out-patients appointment for an x-ray, prescribed analgesia and went home to her mother's address.

During this visit there was no evidence of suicidal ideation or evidence or Community Mental Health Services involvement.

A CAADA DASH Risk Indicator Checklist was carried out and she scored 10. The nurse used her professional judgement and made a referral to MARAC with Mrs C's consent.

This is good use of professional judgement by the nurse as the MARAC score is normally 14 for a referral.

However the MARAC referral was rejected. The grounds offered by the North Wales Police are as follows:

"*Mrs C and her partner was never subject of this area. The reason was that she was supported by Women's Aid having been assaulted by her partner in Hampshire. By this time she had extricated herself from the relationship and was doing everything necessary to safeguard her own welfare. She did not make any suggestion that the relationship was anything other than at an end. The assault had taken place in Hampshire and the perpetrator was housed there. He originated from the South. She was offered support and was adamant that she had a supportive family in the Wrexham area and felt the risk of him coming to this area to be minimal".*

Panel Observation:

The fact that the abuse did not take place in the area of the MARAC referral is irrelevant. Mrs C had travelled to escape the abusive relationship.

It is a known, even intrinsic, characteristic of DVA relationships that an abuser will go to very great lengths to maintain the relationship. In this case Mr C did revive contact via text and phone with Mrs C and successfully restored the relationship. He was commuting from Hampshire to live with her in North Wales when not working.

The professionals in this case could have taken a precautionary route, trusted the professional judgement of the referrer and their knowledge of DVA behaviour patterns, even in the face of the word of the victim that suggested all would be well. The MARAC referral should not have been rejected.

14 July 2010

Mrs C visited Welsh Women's Aid/IDVA caseworker. She said that there had been an incident at the weekend where her husband had physically assaulted her. Mrs C showed staff her injuries. Safety and housing was discussed. Issues discussed in depth included relationships and power and control. Mr C had a tendency to twist situations to blame Mrs C this was discussed and Mrs C was able to recognize how Mr C had been controlling and isolating her, she mentioned several incidents. Advice given concerning a non-molestation order, advised to give all the details to a solicitor. IDVA service explained. Follow up was agreed to see how she was getting on

August 2010

The IDVA caseworker discussed consideration of a MARAC 62 with her superiors.

Mrs C was contacted on 4th August by the IDVA worker. Mrs C reports Mr C has not tried to contact with her (this was untrue). She visited the solicitor regarding a non-molestation order and supplied them with photos and information. She thought an application was being made, however the caseworker discovered that only warning letters had been sent to Mr C and his

father. She also signed her divorce petition. The MARAC referral was discussed and Mrs C said she felt there was no need as 'he has had his knuckles rapped and wouldn't bother her'.

Mrs C accessed the Welsh Women's Aid drop in service for advice and support around ending her relationship with Mr C. An appointment was made for 16th September to see a solicitor with reference to obtaining a non-molestation order.

16th August 2010

Mrs C contacted the Welsh Women's Aid caseworker by telephone. She reports that Mr C had driven up and had attempted to obtain her medical records behind her back. Mrs C revealed that her cousin had texted Mr C and told him she (Mrs C) had had a miscarriage. This resulted in a text dialogue that ended with Mr C saying he was going to talk to a solicitor about her threatening texts. Caseworker strongly advised her to go back to solicitor and get a non-molestation order asap.

17th August 2010

Missed appointment with Welsh Women's Aid. 27th August telephoned and asked Mrs C to contact.

8th September – 22nd September contact with IDVA worker

Mrs C texted to say things had become worse. Mrs C receiving long term support from Women's Aid. Re-consideration of MARAC. Checked if there was an ICAD (TAU) on property. A solicitor's appointment was made for 16th September to organise a non-molestation order. It is not known if this appointment was attended.

17th September 2010

Last telephone contact with Welsh Women's Aid.

December 2010

Divisional Officer Navy requested welfare contact with Mr C over his marital difficulties. Mr C saying Mrs C sending him abusive texts and it was getting out of hand. Concerned that she was violent having grabbed him around the throat before and stabbed someone else. Confirmed the story about the alleged miscarriage (and that his mother is very ill in ICU). Concerned he may harm himself.

In Wales Mrs C continued divorce proceedings with a solicitor. Mrs C was living with her mother. At the time her mother reports that it felt like Mrs C was troubled about something and asked her if they were going to make it up or get divorced. Mrs C said 'I can't turn my feelings off for him'. Mrs T told her daughter she needed help and support to sort it out.

Mrs C now back in contact with Mr C but had not halted divorce proceedings. There is independent information given to her mother that later in the year the couple were secretly meeting and occasionally staying together at a hotel in Wrexham.

2011

January

Mrs C was still living with her mother. The victim's mother then becomes aware that when the couple were setting up the cottage they had spent £5000 on furniture. This became a contentious issue between mother and daughter when repayments weren't made leaving Mrs T in debt.

One evening Mrs C went out for drinks with friends and came back drunk. She got into an argument with her mother in front of her daughter and assaulted her mother. Family relations with Mrs C had been deteriorating and after this incident she was told to leave the home. Her mother Mrs T said they loved her as a daughter but didn't recognise the person she had become and couldn't have anything more to do with her. Mrs T was also grieving the loss of her husband of 54 years at the time. The family didn't trust Mr C and was convinced he manipulated Mrs C and that he never helped her.

Mr C says his wife got in touch saying she 'wanted her husband back' he claims to have told her 'things have got to change' as regards her outbursts and she agreed. Mr C claims that 'something happened in Wales' as when Mrs C returned to him she had nothing, no money or clothes as if she had left in a hurry. There was no further family contact and only one member of her family attended her funeral.

Mr C found out after her death there was a suggestion that Mrs C had assaulted her mother and stolen £5,000. Mr C has been unable to gain any insight from the family. For him what might have happened remains speculation. However, he knows she had no money when she returned to him.

11th The police are called to a verbal argument between the couple at their address in Hampshire. Mrs C being told to leave by Mr C. He was leaving for work in Yeovil. No further action by police. It would appear Mrs C stayed.

Mrs C's GP medical records are transferred to Somerset. A review of the notes references a history of family problems (involving her brother), two assaults (NACRO and Hampshire) and DVA (one incident with Mr C) and long term prescription of anti-depressant medication.

April 2011- December 2012 – Mrs C attended Yeovil District Hospital for appointments that included outpatient oral surgery, routine orthopaedic surgery and an appointment with a cardiologist.

September 2011

GP records state Mrs C wanted to reduce her anti-depressants to be ready for a possible naval exchange to Australia in 2014. She had a reduced dose until November 2013.

2012

June

Avon & Somerset police records state that police received a report from a member of staff at a petrol station saying that a car (registered to Mr C) was being driven by a female who appeared to be very drunk. The male passenger who paid for the fuel also appeared very drunk. The PNC shows that Mrs C was arrested the same day in Wiltshire. She was later disqualified from driving.

October

Mr C left the Royal Navy to work for an aviation manufacturer.

2013

10th October

Mrs C attended the Emergency Department. She was brought in by ambulance after being found on the floor at home by her husband when he returned from work. At the time he found her she was unresponsive, he called an ambulance. The ambulance crew found Mrs C lying on the living room floor. Her Glasgow coma score was 6/15 but rose to 14/15. She appeared confused. There was an episode of unresponsiveness in the ambulance that rapidly resolved.

Mrs C was booked in at 19.00. Medical tests were conducted. Mrs C told the ED sister she was under stress at work and at home and had been drinking vodka but didn't want her husband to know. Her blood alcohol level was high.

A Dr took an initial history from Mr C and then examined Mrs C who was able to provide additional information. The Dr's impression was that Mrs C was suffering from alcohol intoxication, alcohol dependence and depression. She was given the appropriate medical treatment and a referral was made to the alcohol liaison team. She was advised to attend a follow-up with her GP in respect of her depression. Dr noted that the alcohol liaison team should contact via Mrs C's mobile number as she stressed she did not want her husband to be aware of the referral.

Mrs C advised the Dr she had been drinking heavily over the last 7 weeks with no alcohol free days. She did not think her husband was aware. She had seen the GP two days ago for a chest infection. She had been taking anti-depressants but had not suffered any thoughts of deliberate self-harm. She reported difficulties with sleep and thoughts of suicide (she wanted to be with

her father – who had died in April 2010) but with no intent or plans. The hospital notes report that she disclosed verbal and physical abuse by her husband.

Mrs C agreed to an alcohol service referral but was adamant that her husband mustn't know. This was underscored in the records alongside her mobile number. Mrs C was seen by the Alcohol Liaison worker on the same day at hospital before the release.

Whilst it is not recorded in the notes the Somerset Drug and Alcohol Service (SDAS) Turning Point Team Manager recalls a conversation with the alcohol liaison worker (who has left the service). They discussed a way forward which involved attempting to contact Mrs C via mobile phone to make an appointment. Mrs C was insistent that her husband should not know that she had been referred for help with her alcohol use and this was underlined on the written referral. The usual process is to immediately send out the Severity of Alcohol dependence question along with alcohol audit tool on receipt of a referral order to be able to prioritise the referral and this is not recorded as happening until five days later, this is likely to be as a result of the Alcohol liaison worker being unable to make telephone contact.

There was no consent at that time to contact the GP. In the light of this there is now a directive of obtaining consent for the GP when taking a referral in order to be able to inform and follow up with GP. By the 8th November Mrs C had not returned the questionnaire and her file was closed.

19th November 2013

GP visit – Mrs C saw a different GP than usual. She reported that she was under a lot of stress, looking for a new job saying she 'can't cope with anything at the moment'. She struggled to get out of bed and is waking in the night. When it's time to get up she thinks 'what's the point?' GP increased anti-depressant medication to be reviewed in two weeks and gave her a sick note for a week.

29th November 2013

Mr C reports he was getting ready for work and accidently trod on Mrs C's handbag. He heard a cracking noise and realised he had broken her i-pad screen. This revealed that she had been looking at explicit adult sexual material. This caused an argument because there was an agreement they would only look at this type of material when they were together. This argument sparked everything else off and continued throughout the day via phone and text. Mr C left work early to deal with it but saw Mrs C leaving for work and did not talk to her. On Mrs C's return from work at 10pm the argument continued.

Mr C claims she just went absolutely mad and he had to throw her off him he pushed her in self-defence causing her to sustain a head injury. He described her assaulting him by spitting, grabbing his face, genitals, hair, ears, and trying to knee him in the face. He left the home briefly after this attack and then

returned. He then described another historical incident when they were living in Hampshire. On that occasion she had gone mad and chased him with a knife and repeatedly stabbed at the door he had shut behind himself.

Once the argument died down he went to speak to Mrs C who was in bed in the main bedroom saying 'look we need to sort this out'. She was upset and said something like "I'll be out of your hair soon", and 'it's too late now I've taken the tablets'. He asked what she meant and she replied 'maybe I have maybe I haven't, what do you care?' Mr C said he had to know because he was going to call an ambulance. Mrs C said 'don't you dare, don't you dare and if you 'phone I won't go anywhere, I'm staying right here, don't you dare phone an ambulance'. Mr C asked her again if she had taken something but again she refused to say. Mr C said from where he was standing at the bedroom door he couldn't see any physical evidence of pills or boxes, if he had he would have called an ambulance. He didn't fully enter the bedroom (which is very small) in case she went for him again. Mr C said 'this is silly, I am going to go downstairs and go to sleep' Mrs C lay on the bed and said she was going to sleep. Mr C found her in the morning and her note to him was in the kitchen.

30th November 2013

Police officers are called to the sudden death of Mrs C by the ambulance crew.

Police were aware that a violent argument had taken place the night before. There were some differences between Mr C's account and the injuries found on the victim's scalp. As a result Mr C was arrested on 3rd December on suspicion of murder. However the post mortem confirmed the likely cause of death as suicide the conclusion of the CID was as follows:

"Overall the professional medical opinion was that Mrs C died as a result of the combined toxic effects of dosulepin (dothiepin) and codeine. There were injuries suggestive of a recent altercation but no evidence to suggest that it resulted in significant internal injury that could have contributed to her death in any way. The two superficial cuts over the right side of the neck were in a pattern strongly suggestive of self-infliction".

The forensic examination also noted a fatty change of the liver consistent with long-term effects of alcohol misuse

3.4 Family Accounts

The victim's mother and husband contributed to the report. Their perspectives add depth to the records held by agencies and bring the 'victim's voice'. To the report

The victim's mother said that her daughter was bright, strong willed and clever. She was a fiery red-head who was able to take care of herself. As a child Mrs C had a temper but was never violent.

November 2007

Mr & Mrs C met online in November 2007 and once he met her he thought that he really liked her. At first he thought she was 'absolutely brilliant, she was fun, happy, pretty and really looked after herself'. Mr C went to sea in January 2008 and was away for six months he now thinks they rushed into the marriage in August 2008.

Mr C said he didn't know anything much about her first marriage as she never really discussed it. Mrs C said she wanted to cut all ties with Wales, she never spoke to her parents and although she had two children they were with their father and only visited very occasionally. At the time her daughter would have been about 8 and her son about 14. Mrs C's mother confirmed that she had trouble settling down after her divorce and seemed troubled. Once she met Mr C he seemed to be an escape route.

October 2008

Mr C then recounted the assault on them both. When asked about the impact he said that Mrs C never really talked about it very much.

In his view the incident was avoidable and was in large part caused by Mrs C 'gobbing off' at the lads provoking them to attack. The impact of the October assault went on for a long time; he reports that Mrs C got to the stage where she wouldn't leave the house even to get a pint of milk. She wouldn't ever discuss it with him. Both received counselling.

December 2008

Mr C recounts that her angry outbursts were frequent and violent. He recalled the December 2008 incident when they had got into an argument over his children. He describes her as going completely crazy, she ripped the Christmas tree down and stamped all over the presents she was out of control and he called the police. She drove off to Wales. He was unable to recall or explain why she would have gone to the GP with black eyes and facial bruises five days later.

Mr C was aware that there were issues of violence in her background but not the number of incidents or details. He suspected her brother was involved. He was unaware of the historic assault on her at work. He only became aware of her assault on a former partner by accident. When in Fareham Mrs C got a job that required a CRB check. She was let go from the position once it was clear that she had been cautioned for ABH for stabbing a partner. When Mrs C recounted to Mr C why she had lost the job he says he was absolutely shocked.

Mr C was unaware that Mrs C had been treated for depression since 1998. He revealed that when he cleaned the house after her death he found a lot of pills. The police found a lot more during their search especially codeine as well as prescription drugs.

Mrs C used to get particularly agitated over issues concerning his access to his children and his relations with his former partners 'inventing problems' when there really weren't any. She used to sulk, drink and start arguments, in the end he wondered if it was worth seeing his children.

2009

When discussing her drink disqualification of 2009 Mr C acknowledged there was a problem with drinking in the relationship. He knew she drank every day, mostly beer, wine, cider. He couldn't say whether or not she had a problem with alcohol. He used to say she was drinking too much but she would brush it off saying it relaxed her.

There was violent incident between the couple in 2009 where both received minor injuries and this was another incident where she went 'completely crazy', packed her bags and went back to Wales. At this point Mr C felt the relationship was doomed; there was no stability in it. Everything that was discussed just turned nasty. Mrs C returned to Wales and lived with her mother and father.

In Wales the victim's mother recalled seeing that Mrs C was covered in bruises all over her body including her bottom, Mrs C explained that she fell which her mother thought wasn't right but Mrs C refused to let her mother help. The victim's mother was concerned enough to make appointments for Mrs C at the local GP but she refused to go. Her mother was convinced something was very wrong.

Mr C said he was unaware that Mrs C had started divorce proceedings. He was aware that there was an alleged miscarriage and he phoned the hospital to try and find out if it was true. He wasn't seeking to access medical records as such. When asked about injuries to Mrs C in the July when she returned to Wales he said these were probably caused by him acting in self- defence as she probably went mad at him again before leaving. He was unaware of any non-molestation orders or visits to solicitors about divorce.

2010

The couple reconciled briefly and lived together in a cottage in Wales. Mr C commuted to his work in Hampshire. The police were called to a disturbance, according to Mr C his wife was threatening to stab him in front of his son. He says the police were concerned enough to offer him and his son a place of safety. Mrs C's family said he was abusive of her son's mild disability which provoked her.

The victim's mother said she was always uneasy about the relationship saying it didn't feel right. She also didn't like the way Mr C referred to Mrs C's son, she didn't trust him and thought he was manipulative. Trouble brewed again and Mr C left the home to live back in Hampshire. He returned later to collect

furniture, another argument ensued requiring police attendance. He said he had not had dealings with the police or violence or anything like that until he met Mrs C. (This statement is not in accordance with police records that report violence with his former partner). Mrs C returned to live with her mother in part to help with the care of her father who had terminal cancer.

Once the couple were separated Mr C said he knew that Mrs C was into some 'very bad' sites to find married men for sex. He says he knew about four of them and one phoned him up demanding to know where his wife was. There is no independent verification of this information. In May Mr C reported to the police continually threatening and abusive text messages and telephone calls from Mrs C.

Mrs C returned to Mr C in January 2011 saying 'she wanted her husband back'. He told her things had to change. Mr C was away at sea for long periods during 2011. The couple moved to Somerset in 2011.

October 2012

Mr C left the Royal Navy.

2013

When told about the level of drinking Mrs C revealed to the Dr at the time of her collapse and visit to the Emergency Department Mr C appeared shocked and said he knew nothing about anti-depressants or alcohol. Mr C described how their shift work meant that they were often apart from 6am to 10pm and this gave Mrs C ample time to drink before she went to work at 2pm.

Mr C also recalled a time when they were going to the cinema with his son and she seemed absolutely out of it, really quiet, wouldn't talk, just completely in her own world, and then she snapped out of it on the way to the cinema. When she saw an advert for vodka with gold in it she let slip she'd tried it but then tried to cover it up.

Mr C recounted the events prior to Mrs C's death as previously described in the narrative chronology. He says he didn't know she was depressed but recalled that occasionally she would say 'there's no point in me being around' and he would say 'don't be so silly'. Finally Mr C said that he had to defend himself against her outbursts on a number of occasions but that he never beat her up, or gone for her, that he was not a violent or nasty man.

Mr C repeated that he didn't know the woman he was married to, what she was thinking, what went on in Wales, why she didn't see her children or mother, why only her brother came to her funeral, he knew little of her past or what might cause her to be so unhappy and why she didn't confide in him.

Mrs T the victim's mother contradicts this account and says he was aware of all of the issues and that he lied to the police.

Analysis

Mr C portrays himself as the victim in this relationship who was the subject of violence by his wife. He was careful to explain about her quick temper, verbal and physical assaults on himself and others. He also professes to be ignorant of much of Mrs C's past history especially relating to her marriage and family relationships. He also denies knowledge of the extent of her drinking and prescription medication.

Comparing Mr C's account to the official records and information given by others Mr C's account appears to be inaccurate, inconsistent and therefore not credible.

In her account Mrs C's mother expresses her suspicions of him and his manipulation of her daughter. In her mind she believes that Mr C never helped Mrs C but controlled her and this is in part responsible for her daughter's death. She knows that Mr C has lied to the police. He told them he knew nothing about the family which is completely untrue. She believes he told the police he had no family which is also untrue. She never wants to see Mr C again.

In summary both Mr C and Mrs T's accounts confirm that Mrs C was assaulted by others as documented. They also confirm that she assaulted others usually in drink. Both accounts agree that Mrs C did not discuss difficult family or emotional matters with those close to her nor did she discuss with them her issues with drink or anti-depressant medication. She also did not discuss DVA with her mother. Both accounts agree that Mrs C drank consistently but neither account confirmed that there was knowledge about the extent of her drinking prior to her death until the hospital admission.

4.0 Findings

4.1 Avon & Somerset Constabulary IMR Analysis

On the day of death the correct staff was deployed and the initial consultation between attending officers and line managers took place in line with the Avon & Somerset Constabulary domestic abuse policy.

The case presented as a suicide but the PM identified areas of concern and a forensic PM was arranged without loss of evidence.

Once deeper research was conducted the family domestic history became evident.

Lessons Learned

The response in the case was proportionate given the information available at the time. However, the officers were unaware of information held by the Ministry of Defence, Hampshire Police, Yorkshire police and Welsh police about the individual's history and history as a couple. All domestic abuse

victims should have a record that is available to all police forces to identify couples who have a domestic violence history and make the information available via the PND.

Information held by the MOD regarding forces personnel should also be shared. Local police and support agencies would benefit from the history and could co-ordinate a specific response based on that history and concern.

Recommendation One

MARAC and MAPPA processes do not currently cover those cases that are not considered high risk or have not yet been referred by any agency dealing with the victims or offenders. A PND flag would alert officers on first attendance that there is further information on DVA and follow it up quickly giving focus and direction, identifying all agencies involved.

Recommendation Two

The identification of a specific family welfare officer on all MOD stations would be invaluable to exchange information and concerns to police forces even if outside the remit of MAPPA and MARAC.

A national approach is needed to MAPPA and MARAC and it should include the MOD. Currently police forces manage by local agreements only**.** MOD personnel to be trained in the MAPPA and MARAC referral process.

4.2 Ministry of Defence/Armed Services

The Panel discussed the issue of liaison between the MoD with regard to

Policing
Health – primary care level
Alcohol and Drug Services
Safeguarding Adults and Children

Liaison between the armed services and the equivalent civilian services for intelligence-sharing and cooperation purposes seems to be uncovered by an approved protocol.

It was also not known by the panel what level of expertise exists in the Armed Services regarding domestic abuse and violence, drug and alcohol support. It was also unclear what level of support is offered to the partners of military personnel. This arises in respect of MoD taking no action against Mr C in respect of DVA assault when informed by North Wales police and on another occasion asking Mrs C to leave married quarters when there was a joint

assault.

In Somerset RNAS Yeovilton is a significant presence. The County Council led services endeavour to establish and maintain links at an operational level. However, these links are not formalised and perhaps should be particularly with regard to MARAC and MAPPA work. This is an issue that should perhaps be considered nationally.

The Armed Services also do not appear on the statutory list of agencies/organisations required to take part in DHR reviews. This should be reviewed with a view to requiring their participation when military personnel are involved.

Panel Recommendation 1.

The identification of a specific family welfare officer on all MOD stations would be invaluable to exchange information and concerns to police forces and health services even if outside the remit of MAPPA and MARAC. A national approach is needed to MAPPA and MARAC and it should include the MOD. Currently police forces manage by local agreements only**.** MOD personnel to be trained in the MAPPA and MARAC referral process.

4.3 Turning Point Analysis Somerset Drug and Alcohol Service IMR Analysis

At the time of Mrs C's death the service had rigid treatment pathways that did not always allow for flexibility. Mrs C was offered support within the service guidelines at the time. A review of the service in February 2014 and a restructuring of the service as a whole now allows for a more flexible approach to need. Referrals are no longer closed if the audit questionnaires are not returned and a more robust follow up process will try to engage the client.

The service has recognised that less experienced staff may not be equipped with the skills to carry out in depth discussions with a client around the issues of DVA and what actions are necessary. There is now mandatory training in DVA and all staff has information available as to what actions to take including a greater awareness of their ability to make a professional referral to MARAC and other support services. All staff has the opportunity to attend MARAC as part of this process.

Recommendation 1.

That all files are reviewed with senior staff before closure

Recommendation 2.

That the training and familiarisation regarding professional MARAC referrals and issues around DVA are continued.

4.4 Somerset Clinical Commissioning Group (GP) IMR Analysis

It is of concern that when individuals are with the armed forces and able to access health services from the medical officer that they are seen and assessed only for that consultation without full assessment of risk for the wider family unit. The services medical record is limited which then in part provides a medical history for the primary care GP surgery to inform subsequent consultations and decision making when seen in consultation following reports of violence. This is particularly pertinent if both armed medical services and primary care services are being used to ensure that a seamless current medical record is maintained. It is unclear from the historical records about the whereabouts of either partner's children from previous relationships.

Just before Christmas 2008 Mrs C presented to her GP with two black eyes, apparently from a fall landing onto her face. The record does not contextualise this incident.

GP Surgery

Mrs C was generally seen by her own (female) GP. Medication for anti-depressants as previously detailed. The GP followed good practice when asking Mrs C specifically about domestic violence and whether or not she felt safe. Following the domestic incident in 2011 and her assurance that she felt safe there was no further disclosure or reported incident of violence of any kind against her, or her husband. The issue of alcohol dependence was not mentioned to the GP and there was a reluctance to share why she had left her children and unclear whether she was seeing them

The GP surgery was aware of the hospital admission but minimal details were received.

Lessons Learned

It is unclear from the consultations before Mrs C registered with the recent surgery that there was any consideration as to the potential risks presented pertaining to DVA and if the children from her previous relationship were affected. It is paramount that the safety of children should be considered if and when there is any reported violence.

It is good practice for surgeries to review and produce a summary of previous medical attendance and significant problems to inform future consultations and not rely on the patient providing the history. This practice has been emphasised to staff recently.

It is good practice that the GP specifically sought clarity on registration whether there was any current concern or history of DVA given the historical information recorded and detailed by the patient.

This GP surgery has a DVA lead who was also Mrs C's GP. This GP attends annual safeguarding training which includes domestic abuse and is aware of

the local services for referral. She provides updates to the practice staff, particularly GPs and nurses. The GP is aware of CAADA. The last training was in February 2014.

Since the death of Mrs C a significant event review has been conducted. Learning has included a review of having difficult conversations.

Recommendation 1.
Feedback and debrief to be offered to the general practice prior to final publication, including the good practice regarding the historical summary of medical records and seeking clarity if there was any history of domestic abuse.

Recommendation 2.
For individuals or families who access part of the medical services from the armed forces, consideration should be given as to how this information should be shared with the primary care GP to inform holistic assessments of need, Where there are identified risks or suspected abuse this should follow the child protection and adult at risk safeguarding referral procedures.

Recommendation 3.
Circulate lessons learnt from DHRs regarding the need to clearly document who is the primary carer for children.

Recommendation 4.
Share good practice with GP practices.

Recommendation 5.
That GPs follow up hospital attendance discharge notices with the hospital and or patient. Especially regarding those patients who have a known history of DVA, long term prescription of anti-depressant medication, substance misuse, or mental health issues.

4.5 Yeovil District Hospital NHS Foundation Trust – IMR Analysis

The Trust's involvement with Mrs C was reviewed. The emergency department does not use a formal depression score and in the absence of any self-harm there was no reason to use the risk matrix. Assessments made by the medical staff were as expected for a patient presenting in her circumstances.

The referral to the Alcohol Liaison Team is written and these are taken from the emergency department on a daily basis. Mrs C agreed with the referral but emphasised her husband must not be told

There was no evidence of gaps in knowledge or of inappropriate resources being deployed. There were no delays in procedure or delivery of service. However a referral to a DVA service was not made.

There was evidence of good practice in terms of full assessments and

identification of issues at the time of Mrs C's Emergency Department attendance. Referrals were appropriate and documentation completed.

A hospital discharge notice was sent to the GP but did not contain notification of the DVA or the referral to Turning Point. Therefore denying the GP the opportunity to contact the patient for a follow up.

Recommendation 1.
That a review is undertaken of hospital discharge notices and that all relevant information is sent to the GP e.g. especially including disclosure by the patient of any unusual behaviour or experiences e.g. violence or fear of violence, referrals to specialist agencies for alcohol or substance misuse or DVA advice.

Recommendation 2.
The photocopy of the hospital admission record given to the DHR Review demonstrated a very poor standard of record keeping. The form was not completely filled in, the writing was illegible in many areas and the key piece of information regarding DVA disclosure was written in a margin sideways and was missed on the first pass by the DVA author who was specifically looking for this type of reference. Instruction should be given to all Emergency Department staff on the importance of full, good quality, complete, legible records for the purposes of onward referrals and potentially later investigations into processes.

Recommendation 3.
That every time a disclosure of DVA is made appropriate referrals are made immediately and not left to a third party or agency to pick up.

5.0 Findings

The terms of reference required this report to

- To establish a profile of Mrs C and her familial and close relationships.
- To establish if family, friends, colleagues, or employer, wanted to participate in the review. If so, to find out a) if they were aware of any abusive behaviour prior to her death and b) if there were indications that Mrs C may take her own life
- Whether in relation to family members or colleagues, where there any barriers to reporting suspected abuse. The extent of Mrs C's contact with any specialist domestic abuse agency or service in the County. To consider if there were any warning signs which were not acted upon

These objectives have been achieved and a summary of key points follows:

Mrs C had a relatively stable and supportive family background in North Wales.

Mrs C had a 15 year history of anti-depressant medication. As a result of an arm injury Mrs C also took large quantities of strong pain killers. She was also known to have a long history of misusing alcohol and this was known to have escalated in the seven weeks or so prior to her death. Her drinking was also linked to violent behaviour.

Mrs C was the victim of serious assaults during her life. First at her work with NACRO, second at the hands of her partner in Yorkshire in 2007, third in the attack by youths in 2008 and finally by Mr C in July 2010.

Mrs C was known to have a strong personality and fiery temper and it is known she became violent when in drink. She attacks her former partner in York and was cautioned for stabbing him. Mr C claims that she assaulted him often and threatened him with knives. She also assaulted her mother in full view of her daughter.

After the incident of assault on her mother she left her family in Wales and had no further contact with them. She left to reconcile with Mr C. From this point to her death Mrs C's use of anti-depressants continued, her use of alcohol escalated.

The relationship between Mr and Mrs C was violent. Mr C's account that he was an innocent victim of her violence is not credible and there is significant evidence that both partners seriously assaulted each other.

Mrs C related to Welsh Women's Aid Mr C's tendency to twist situations to malign her and manipulate the truth. For example Mr C relates Mrs C's actions in relation to using the internet to find sexual partners, watch explicit material and using text and phone messages to harass him. He does not acknowledge any responsibility for his own part in the same activities.

In terms of barriers to discussing DVA as described in the chronology Mrs C took opportunities to report DVA to specialist agencies and did so on numerous occasions. She received good support and assistance in North Wales. However, on the last occasion in Somerset the information disclosed to the hospital/Turning Point was not passed to her GP nor was she referred to a specialist DVA organisation which was a missed opportunity for intra-agency working.

However Mrs C did not always take up referrals nor make full disclosures to her GP so it cannot be said that this would have necessarily changed the outcome.

6.0 Equality & Diversity

There were no equality and diversity considerations in this case.

7.0 Conclusions

Predictable?

In deciding whether or not Mrs C's death was predictable it can be evidenced that prior to her death Mrs C was living under a number of significant stresses which may have had more or less impact on her general well-being and mental health:

- Once the relationship with her family had broken down following the assault on her mother Mrs C may have felt she had no option but to return to her husband and was dependent on the relationship for the last 22 months. Mrs C may have felt trapped in a failing and violent marital relationship.

- Mrs C was isolated from her family. Her family say that she had 'burnt her bridges' with them.

- Mrs C was estranged from her children. It can be speculated that the arguments with Mr C about access to his children and relationships with former partners may have arisen out of jealousy and/or her feelings as regards missing her own children.

- The cumulative effect of years of prescription and over the counter drug taking combined with the misuse of alcohol and a turbulent relationship will all have played a significant part in the final months of her life. These issues escalated significantly in the final weeks.

- Mrs C was known to have been a bright woman but her criminal record and the restricted ability to travel due to her drink drive disqualification meant she was unable to access the type of work of which she was capable. She worked on the production line of a local cheese factory which was well below her capabilities, she reported it was stressing her and she was looking for other work.

Mrs C's mood and behaviour dramatically worsened in the last 7 weeks of her life. She pinpoints this to a paternity issue over Mr C's daughter although he denies this was ever an issue.

Preventable?

Throughout the period of the terms of reference Mrs C accessed specialist help and disclosed DVA to the police, health professionals and specialists North Wales. There records indicate the help and support she received was appropriate, of a good standard and in line with the processes, policies and procedures in place at the time.

In Somerset Mrs C did not seek help for her drinking and or disclose DVA to her GP. Once her level of drinking and DVA was disclosed to the hospital an appropriate referral was made to the alcohol liaison worker and she was seen the same day. Turning Point worked in a timely way and within the procedures operating at the time. Mrs C failed to respond to later correspondence sent to her.

There were no barriers Mrs C accessing either general or specialist help. She was specifically asked by professionals on two occasions in the last two months of her life if she was suffering verbal or physical violence. To her GP she expressed that she felt safe but to the hospital disclosed verbal and physical abuse. On a subsequent visit to the GP 10 days before her death Mrs C did not mention DVA or drinking.

The hospital records show patient disclosure information concerning DVA and serious alcohol dependency yet this was not shared with the GP. This can be considered a missed opportunity to practice effective multi-agency working. Mrs C's GP is the DVA lead for the practice and would have been able to broach the matter with her if aware.

However, it is also true that Mrs C did not take up the appointment made at Turning Point so it is equally possible that she would not have taken up a DVA referral had one been made.

Finally, there is also evidence that Mrs C's own impulsive nature was exacerbated by alcohol misuse. Impulsivity is a known characteristic of substance misuse in which individuals do not always consider their actions in light of the consequences. This can lead to high risk behaviour with outcomes that are not always intentional.

Therefore it is possible to conclude that in all the circumstances that with the information known at the time that any actions that either were or could have been taken by the agencies would have prevented this death.

8.0 Recommendations

See Appendix A

Glossary

A&E	Accident and Emergency
CAADA	Co-ordinated Action Against Domestic Abuse
CCG	Clinical Commissioning Group
DASH	Domestic Abuse Stalking Harassment and Honour Based Violence
DCI	Detective Chief Inspector Avon & Somerset Constabulary
DHR	Domestic Homicide Review
DVA	Domestic Violence and Abuse
ED	Emergency Department
DI	Detective Inspector Avon & Somerset Constabulary
GP	General Practitioner
HMICS	Her Majesty's Inspectorate of Constabulary's
IDVA	Independent Domestic Violence Adviser
IMR	Individual Management Review
IRIS	Identification & Referral to Improve Safety
MARAC	Multi Agency Risk Assessment Committee
NHS	National Health Service
PCC	Avon & Somerset Police & Crime Commissioner
PCSO	Police Community Support Officer
PNC	Police National Computer
PND	Police National Database
PPU	Public Protection Unit Avon & Somerset Constabulary
SSP	Safer Somerset Partnership

Appendices

Appendix A Action Plan

Appendix B Letter from the Home Office Quality Assurance Panel (TBA)