Wiltshire Safeguarding Vulnerable People Partnership Domestic Homicide Review

Overview Report Executive Summary regarding Emily who died in May 2020

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A message of condolence

The Domestic Homicide Review Panel wishes to express its condolences to the family and friends of those affected by the events described in this report. The panel hopes that the process will provide some answers to their questions.

Introduction

1. Emily was a young woman who at the time of her death, was living with her parents in Wiltshire. She had returned to live with them following a period where she had been living in supported housing, spent time in rehabilitation services and lived independently, including with her boyfriend.

2. Emily had a history of mental health problems and drug use.

3. She was born in Hampshire and was brought up in Wiltshire, following her parent's move to the area when she was two years old. When she was born, Emily was diagnosed with a hearing impairment. She experienced persistent problems with her hearing throughout her life.

4. During her early schooling, Emily experienced bullying from other pupils. Her mother described her as having been a sensitive child and that from the age of 10 she began to experience mental health problems; her mother believes that these began as a result of the bullying Emily experienced. She began to self-harm from the age of 12, often cutting herself with razor blades and sewing needles.

5. Mental health support was sought for Emily by her parents.

6. In 2013 Emily alleged that she was the victim of rape. The suspected assailant was a boy with whom she had formed a close relationship. The boy, known in this report as Jim, was subject to a police investigation. When interviewed by the police, Emily indicated that she had been in a consensual sexual relationship with Jim but on this occasion she alleged he had been violent and forced her to have sex against her will. Jim subsequently received a conditional caution for the offence of an offender under the age of 18 engaging in penetrative sexual activity with an underage female.

7. In 2018 Emily was living in supported accommodation. She found one of her fellow residents, who was at the time in a relationship with her, deceased in her room. His death was the result of drug use.

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8. After a period of living in supported housing, having moved for a time to Dorset, where she remained in close contact with Jim, Emily returned to live with her parents in April 2020. She disclosed to her parents that she had experienced domestic abuse from Jim.

9. Emily was reported as experiencing a worsening of her mental health during this period. She had been attempting to stay off drugs, but her parents feared that she might be using again. Emily went out in the evening two days before her death and her parents thought she might have gone out to buy drugs. When Emily returned home, she went straight to her room and did not emerge. Her parents thought she might have taken heroin. The following morning Emily did not get up and told her parents she wanted to sleep in. She stayed in her bedroom all day and did not want to talk to her parents.

10. Her father was able to engage Emily in a conversation late that night, where Emily acknowledged that she needed help but did not know where she would get it, and was talking about returning to Dorset to be with Jim.

11. Later that night Emily had been up late and had been overheard by her mother on the phone to Jim. When her parents woke up the next morning they decided to let Emily sleep on, and her father went to wake her at around 11.00am that morning.

12. When he entered Emily's room her found her sat upright on the bed, she was unresponsive, and there was a used needle on the floor of the room. An ambulance was called and paramedics attended. Emily was declared deceased by the paramedics.

13. Wiltshire Safeguarding Vulnerable People Partnership (SVPP) reviewed the case and decided that Emily's death met the criteria for a Domestic Homicide Review given the history of domestic abuse she had experienced and that her death was, at the time, unexplained. The Coroner subsequently ruled that Emily's death was a result of an accidental overdose.

14. After her death, a notebook was found in which Emily had written about her experiences. The DHR panel has been able to review those notes.

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The DHR process

15. Wiltshire SVPP oversees the response to deaths potentially requiring a domestic homicide review, through a partnership wide approach to case reviews.

16. This report was approved by the review panel following a panel discussion of the draft, and a meeting to agree the recommendations and action plan. The SVPP Community Safety Partnership Executive Group approved it prior to its submission to the Home Office.

17. No parallel reviews were undertaken or were in train during the period that the DHR took place. A Coroner's Inquest was held and concluded in March 2021. The verdict was that Emily died by an accidental overdose.

18. The decision to hold the Domestic Homicide Review was taken in September 2020 having decided that the criteria set out within The Act was met. The independent chair and author was appointed through an open tendering process in October 2020.

19. The Domestic Homicide Review has been conducted 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.

Contributors to the Domestic Homicide Review

20. Individual Management Reports (IMRs) were requested from the agencies that had been in contact with or providing services to Emily. 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 contact and service provision by agencies with both the subjects of the DHR.

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

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22. Thirteen agencies contributed to the review through the submission of Individual Management Reviews and the provision of initial scoping information. Those agencies were:

    - Avon and Wiltshire Partnership NHS Trust
      (Improving Access to Psychological Therapies Service & Secondary Care Mental Health Services)
    - Broadway Lodge Drug & Alcohol rehabilitation unit
    - General Practice
    - Frowds House
    - Oxford Health NHS Foundation Trust (CAMHS)
    - Rethink Mental Illness (Herbert House)
    - Salisbury NHS Foundation Trust
    - South West Ambulance Service
    - Splitz
    - Wiltshire Council Adult Social Care
    - Wiltshire Council Housing Department
    - Wiltshire Police
    - Wiltshire Youth Offending Service

The agencies identified above each provided IMRs that were reviewed by the panel and used by the panel in reaching their conclusions

Other contributors to the DHR

23. The Chair of the Panel spoke with Emily's parents as part of the review. This conversation took place virtually as a consequence of COVID19 restrictions. The interview was held in April 2021.

24. Emily's parents were provided with information about support and advocacy.

25. Emily's parents were provided with a copy of the draft of the overview report, and had the opportunity to comment on and their reflections have been incorporated prior to its finalisation.

The Domestic Homicide Review Panel Members

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Wiltshire Police	Practice Review Manager
Wiltshire Council	Domestic Abuse Reduction Co-ordinator
Contact Consulting (Oxford) Ltd.	Independent Chair and Author Reviewer
CCG BSW	Designated Professional for Safeguarding Adults
Dorset Police	Detective Constable – Adult Safeguarding Team
Wiltshire Adult Care	Senior Practitioner – Mental Health
Wiltshire Council Children Social Care	Interim Head of Service
Youth Offending Team	Service Manager Young people
Avon & Wiltshire Partnership NHS Trust	Domestic Abuse Lead
Splitz	Phoenix Project Manager
Oxford Health NHS Foundation Trust CAMHS	Senior Named Professional for Safeguarding Children
Salisbury NHS Foundation Trust	Safeguarding Adults & MCA Lead Nurse
Rethink	Associate Director Accommodation Services Rethink Mental Illness
Wiltshire Housing	Head of Housing Operations
Turning Point	Locality Manager Wiltshire
Broadway Lodge	Registered Manager – Deputy CEO
Woodstock / Frowd's House	Service Manager
Wiltshire Safeguarding Vulnerable People Partnership	Interim Board Lead – Quality Outcomes Children's and Families
Wiltshire Safeguarding Vulnerable People Partnership	Partnership Business Support Officer
Wiltshire Safeguarding Vulnerable People Partnership	Partnership Business Support

The members of the panel were independent and had no prior contact with the subjects of the Domestic Homicide Review or knowledge of the case.

The Overview Report author

26. The independent Chair of the panel and 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

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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.

27. 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.

28. 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. He has completed the DHR Chair training modules and retains an up to date knowledge of current legislation

29. Steve has had no previous involvement with the subjects of the review or the case.

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Terms of Reference

- Consider the events leading up to the death, including a chronology of the events in question.
- Consider the relevance and, where appropriate, the effect and impact of the deceased's drug use in this case.
- Consider the nature of previously alleged domestic abuse and the part it may have played in the death of deceased.
- Review the interventions, care and treatment and or support provided to the deceased by services. Consider whether these interventions were consistent with each organisation's professional standards and domestic abuse policies, procedures and protocols.
- Review the communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessments and management.
- Identify any care or service delivery issues, alongside factors that might have contributed to the incident.
- Examine how organisations adhered to their own local policies and procedures and ensured adherence to national good practice.
- Review documentation and recording of key information, including assessments, risk assessments, care plans and management plans.
- Examine whether services and agencies ensured the welfare of any adults at risk, as well as whether services took account of the wishes and views of family members in decision making, how this was done and if thresholds for intervention were appropriately set and correctly applied.
- Whether practices by all agencies were sensitive to the gender, age, disability, ethnic, cultural, linguistic and religious identity of the deceased and whether any additional needs were explored, shared appropriately and recorded.
- Identifying and highlighting any examples of good practice so that these maybe used to inform service improvement and development.

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- Whether organisations were subject to organisational change and if so, did it have any impact over the period covered by the DHR. Had it been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.

- Identifying and highlighting any examples of good practice so that these may be used to inform service improvement and development.

Key findings and conclusions

30. Having reviewed and analysed the information contained within the IMRs and having considered the chronology of events and the information provided, the panel has drawn the following conclusions:

31. The examination of this case has been problematic in the sense that Emily's death has been determined as one of accidental death. This means that no homicide was committed and she did not take her own life within the meaning of suicide. This means that the case does not sit neatly within the framework for a DHR. However, the review of Emily's death has proved to be an appropriate and necessary process to enable learning and improvement for local agencies and professionals.

32. Emily had experienced a traumatic period in her childhood and this was likely to have had a direct impact on her mental health, her use of drugs and the choices she made in respect of relationships. There were also difficulties in her relationship with her parents.

33. The sexual assault Emily was subjected to in her early adolescence was frequently cited in the reports reviewed. Its impact on her was clearly significant. However, she continued to be in contact with the perpetrator and later experienced domestic abuse from him in the months preceding her death.

34. Research shows the links between poor parent/child relationships and how this can have an impact on adult health and outcomes. More recently the part that Adverse Childhood Experiences (ACEs) can play in a person's later life has gained greater recognition and prominence. ACEs are stressful events occurring in childhood. The term was originally developed in the USA for the ACEs survey, which found that as the number of ACEs increased in the population studied, so did the risk of experiencing a range of health

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conditions in adulthood. There have been numerous other studies that have reached similar findings including in Wales and England.[1]

35. Emily was in the process of ending her relationship with Jim. Evidence from research and surveys of victims indicates that the risk of further violence and harm actually increases at the point at which a victim leaves a perpetrator.

36. A study of 200 women's experiences of domestic abuse commissioned by Women's Aid (Humphreys & Thiara, 2002)[2] found that 76% of separated women had experienced post-separation verbal and emotional abuse and violence, including: 41% subjected to serious threats towards themselves or their children; 23% subjected to physical violence; 6% subjected to sexual violence; and 36% stated that this violence was ongoing. There is evidence that the risk of domestic homicide is increased post-separation.

37. Canadian research has indicated that 40% of women and 32% of men who were in a former violent marriage or common-law relationship experienced violence post-separation. Research demonstrates that the risk of lethal violence is particularly high following parental separation, especially within the first few months[3].

38. More recent research in 2017 published in the Journal of Interpersonal Violence found that separated women were more likely than non-separated women to be victims of interpersonal violence in most years from 1995 to 2010.[4]

39. Taking the evidence into account indicates that Emily was at higher risk of domestic abuse and violence due to the fact that she was attempting to end her relationship with Jim.

40. The majority of contact with Emily from statutory and third sector agencies took place outside the timescale for this DHR. However, the information reviewed from beyond that initial timescale provided a helpful range of historical and contextual evidence for the review.

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[1] Adverse Childhood Experiences International Questionnaire. WHO https://www.who.int/violence_injury_prevention/violence/activities/adverse_childhood_experiences/en/

[2] Humphreys, C. & Thiara, R.Routes to Safety: Protection Issues Facing Abused Women and Children and the Role of Outreach, Women's Aid, January 2002

[3] Risk Factors for Children in Situations of Family Violence in the Context of Separation and Divorce, Canadian Department of Justice

[4] Rezey, R. Separated Women's Risk for Intimate Partner Violence: A Multiyear Analysis Using the National Crime Victimization Survey, Journal of Interpersonal Violence February 2017

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41. It is clear that the majority of interventions from services and professionals were of an appropriate standard and quality. Some deficits have been identified, these include:

- The lack of a co-ordinated holistic view of Emily and her circumstances.
- Some examples lack of effective information sharing and communication.
- Gaps in knowledge and expertise in relation to domestic abuse and knowledge, including the lack of routine enquiry.
- Deficiencies in recording of decisions and information received and shared.
- A general lack of professional curiosity displayed by a range of professionals in the various agencies in relation to the risks of domestic abuse.

42. The misuse of drugs and alcohol places individuals at greater levels of risk in relation to physical and mental health, their financial circumstances and their relationships, and as such the Institute of Alcohol Studies suggests that it can increase an individual's overall vulnerability.

43. Emily's mental health and her drug/alcohol problems were of long-standing and were never fully resolved, in part because she was ambivalent about seeking and then sustaining the help she needed. There is no doubt that her drug use in particular remained a key contributory factor to her ongoing difficulties, both in respect of her day to day life, as well as her relationships and the wider choices she made.

44. The connections between domestic abuse and Emily's mental health and her drug and alcohol problems were not always triangulated sufficiently to allow for a more rounded view of the range of issues she faced and how they might best be addressed through inter-agency collaboration.

45. Supporting Emily's wish to live independently was not the best decision given that she was continuing to use alcohol. Giving her further independence raised the risk that she would further accelerate her substance use.

46. No single agency could provide all of the services and support necessary to the complex set of issues Emily experienced and presented.

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47. Emily had been in a relationship with Jim previously and this had restarted when she went to Bournemouth. Little is known about the time she spent there, but it is clear that the domestic abuse she described took place during that period and that she had become fearful for her safety. This prompted her to return to Wiltshire to live with her parents.

48. Throughout her life Emily had been in relationships with males where she had been vulnerable to exploitation and domestic abuse. She had also been vulnerable to other sexual exploitation. The extent to which these experiences affected her is not fully understood, though there was some exploration of them in her contacts with mental health and other support services. However, the knowledge of these events appears to have been superficial and there is little to indicate that a deeper understanding was sought.

49. Towards the end of her life Emily was able to recognise that she was being subjected to domestic abuse. She took steps to disclose this and these disclosures were responded to by the giving of advice about where she could seek specific support. Emily took steps to refer herself to Splitz and this demonstrates that despite her concerns about doing so, she took positive action.

50. There were delays in the response of Splitz to Emily's referral. The evidence indicates that the delay was in part due to capacity issues within the service.

51. There are examples of risk assessment taking place and in the main these were appropriate and of a good standard. However, the broader view of Emily and her risks did not permeate between agencies. This is despite there being evidence of information sharing and joint working. There were occasions where the use of DASH was not undertaken and these should be regarded as missed opportunities to identify and respond to risks.

52. Safeguarding as a process does not feature significantly in the responses of organisations. When it did, its use did not conform to accepted standards of practice, in that it did not sufficiently highlight levels of risk and concern, despite the evidence being available to professionals. This led to a safeguarding referral being rejected.

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53. There is a need to give additional focus to the knowledge, understanding and approach of agencies and professionals to safeguarding and the use of the local frameworks, processes and forms.

54. The overriding conclusion of the DHR panel is that agencies did their best to support Emily. She presented a complex set of needs, combining issues with her mental health and drug misuse, all of which had a contextual factor of the relationships she engaged in.

55. There is no doubt that Emily was a vulnerable young woman and on a number of occasions her vulnerability and lack of self-esteem was exploited by the men she knew, some of whom she had been or was in relationships with. This meant that she experienced domestic abuse of differing kinds over a lengthy period.

56. An earlier referral to MARAC would have provided the opportunity for a multi-agency overview and response to Emily.

57. Emily had experienced trauma as highlighted earlier in this section. Being subjected to sexual attack in her teenage years, then finding a partner deceased must have been experiences that had a deep impact on her. Although there is evidence that these issues were known about by agencies and some of their inputs took this into account, they either did not pursue those impacts in depth, or in some cases, Emily was reluctant to address those impacts.

58. Emily's contact with services is characterised by an initial desire to engage, but a consistent ambivalence and disengagement from those services. This meant it was difficult for services to sustain and meaningful programme of support.

59. Ultimately, it is the panel's judgement that it was Emily's use of drugs that was to prove the most significant contributing factor in her death. However, her experiences of domestic abuse should not be diminished and clearly played a key part in her thinking and decision making.

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Lessons learnt

60. This case, as others have done previously, has shone a light on the challenges that statutory and third sector organisations face in being able to effectively intervene and support people who have complex needs. This is particularly the case of people who sometimes do not wish to take up offers of support and whose lifestyle and personal choices put them at risk. That risk may also be related to a restriction of their own choices as well as their wider circumstances, such as relationships, housing, employment and health, which may place them at disadvantage.

61. Although Emily did recognise that she was a victim of domestic abuse, there were times when discussing her experiences that she used language that have been described as euphemisms in relation to those experiences and in relation to her relationships. This highlights the fact the victims may express their experiences in a range of ways and professionals need to be alert to the use of different language and descriptions when communicating with those who have or may be experiencing domestic abuse.

62. The importance of accurate and timely risk assessment and safeguarding is imperative. This case has shown that there is more to do to ensure practice is consistent and of sufficient quality to enable these processes to be as effective and useful as they are intended to be.

63. The role and impact of family relationships and dynamics are often central to an individual's development, their mental health and emotional wellbeing and the relationships they engage in. This case demonstrates that understanding those family dynamics and tailoring interventions that can respond to those is key in ensuring that holistic services and supports can be offered.

64. There are examples of good practice in this case that can be drawn upon to further embed and learn from.

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Recommendations

65. The Domestic Homicide Review Panel made the following recommendations arising from the review. They were developed in direct response to the key findings and conclusions. The full Overview Report describes the linkages between the findings and recommendations in more detail.

1. Work should take place with the local agencies involved in this case to ensure improved understanding of the referral process for Adult Social Care. This means staff are clear on when and how to refer, and that any referrals they make are of a consistent high quality.

2. Adult mental health services should examine their policies and processes to ensure that they offer adequate opportunities for family engagement in care planning and review of people with complex needs. Services should review current practice and consider what could be improved to address any barriers to involving families in support plans and reviews.

3. The use of the DASH risk assessment should be promoted as the primary tool for assessment of risk in relation to domestic abuse and seek assurance that it is being used appropriately and consistently across the partnership.

4. Agencies should examine current systems for the sharing of information between organisations (including cross boundary) relating to actual or suspected domestic abuse and identify any areas for improvement to ensure that risk to a potential domestic abuse victim can be adequately assessed.

5. The SVPP should promote the learning about the multi-faceted aspects of family members and carers supporting adults with complex needs and encourage all agencies to adopt a standard line of enquiry about identification of carers and provision of information about carer support services.

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