Hull City Council

Hull Community Safety Partnership

Domestic Homicide Review Report:

EXECUTIVE SUMMARY

Adult A

Died: 1 February 2015

Tony Blockley
Director: Johnston and Blockley Ltd

Date: 10 May 2016

File classification: Protected confidential

1. Introduction

This executive summary outlines the process undertaken by Hull Community Safety Partnership Domestic Homicide Review panel in reviewing the circumstances of the death of Adult A at the hands of her partner, Adult B. Criminal proceedings have been completed; Adult B has been convicted of murder and sentenced to life imprisonment. He must serve at least 22 years before he becomes eligible for parole.

The Domestic Homicide Review Panel would like to extend its sincere condolences to Adult A's family and offer continued support to them all.

Adult A and Adult B had been in a relationship for over 30 years, they had one child from their relationship (27 years old) and Adult A had another child from a previous relationship (31 years old).

Prior to Adult A's death they had recently separated and on the evening before her death the two of them had met at a local pub for a meal before checking into a local hotel. About two hours after they had checked in Adult B was seen to leave the hotel clutching the side of his face. From the subsequent investigation he had murdered Adult A in the room. Adult A was found on the morning of 1st February by staff attending to the room, Adult B was later arrested in York.

The judge said at the trial that Adult B had killed Adult A *"With brutal determination"* and added that *"having killed her you left her body in that hotel room and made your departure…that was callous".*

Following agreed protocols, on 5th February 2015, Humberside Police notified Hull Community Safety Partnership (CSP) of the circumstances of Adult A's death. On 5th March 2015, the Domestic Homicide initial Core Group meeting decided that a Domestic Homicide Review should be conducted in accordance with section 9 of the Domestic Violence, Crime and Victims Act (2004) because it was clear that a person to whom she had been related or with whom she was or had been in an intimate personal relationship had caused Adult A's death. At that time the meeting did not feel there was sufficient information available to formulate specific terms of reference for the review.

The following agencies were asked to provide chronological accounts of their contact with Adult A and with Adult B for the preceding three years as agencies had only started to engage with them both from this date.

- Humberside Police
- Hull Domestic Abuse Partnership – Domestic Abuse Support Service
- Hull City Council Housing
- National Probation Service
- Renew Community
- Corner House

- Preston Road Women's Centre
- Humber NHS Foundation Trust (HFT)
- General Practitioner and drug links worker
- Hull and East Yorkshire Hospitals NHS Trust (HEY)
- Together Women's Project

Those agencies produced reports covering the following:

- A chronology of interaction with Adult A and/or Adult B
- What action was taken and to provide an analysis of those actions
- Whether internal procedures were followed and if those procedures were appropriate in light of the death of Adult A
- Conclusions and Recommendations

2. Key issues arising from the review

Adult A and Adult B had little involvement with agencies regarding domestic abuse. They both had minor criminal convictions dating back many years, they were both illicit drug users and Adult B was having a number of difficulties regarding his mental health.

The first recorded incident relating to domestic abuse was in December 2013 when Adult A contacted Humberside police, as Adult B was being aggressive towards her.

A further incident was reported in May 2014 and again appropriate risk assessments and offers of support were given to Adult A. In June 2014, Adult A gave information relating to an assault by Adult B to the GP, Hull and East Yorkshire NHS Trust and the Together Women's Project. Information was provided with regard to domestic abuse perpetrated by Adult B, which included strangulation. From the information available to the review it does not appear that the strangulation was recognised as a high risk factor and at no time did any of the agencies except for Humberside police, complete a Domestic Abuse risk assessment. In the HEY hospital notes it does state that Adult A declined to give information, this is a key learning point from the review. Whilst the lack of any relevant risk assessment did not comply with expected practice and having examined all the available information the panel concluded that the absence of the relevant risk assessment would not have altered the sad course of events.

It should be noted that whilst the GP practice manager did not complete a relevant risk assessment she did offer full support to Adult A, including taking her to the hospital and staying with her throughout Adult A's treatment; this was far in excess of her role.

There were a further three other incidents where domestic abuse risk assessments were not completed, June 2014, July 2014 and one around Christmas 2014 – there is no specific date due to incomplete record keeping. This is a key issue arising from this review; it is every professional's

responsibility to complete an evidence based risk assessment for victims of domestic abuse.

Information has come to light since her death that Adult A had been a victim of domestic abuse during the relationship with Adult B.

The review panel have considered the lack of risk assessment and the potential to change the course of events and concluded that whilst it does not meet expected standards it would not have had an impact on predicting or preventing Adult A's death.

3. Conclusion from the review

Adult A and Adult B were known to services although their engagement was occasional and it would appear that not all incidents were reported. There is no doubt from the review that Adult B was violent and abuse towards Adult A however the review is unable to determine why she did not report the incidents or seek help. There is nothing to indicate there were any barriers to reporting and advice and information was given to Adult A regarding services but these were not taken up.

Nothing has come to light during the review that would suggest that Adult A's death could have been predicted or prevented.

4. Recommendations from this DHR Multi Agency review

Hull Community Safety Partnership

- There should be a single cross agency risk assessment that can be shared and used by all partners across the Hull area when supporting individuals.

- A single risk assessment process should be introduced and utilised by all partners within the Hull area.

- The Hull Community Safety Partnership should design and implement a common language for all organisations to create a standardised understanding relating to risk thresholds and MARAC criteria.

- Review of the current training and awareness provision and ensuring the cumulative effect of domestic abuse and coercive and controlling behaviour and also the impact on children is highlighted and understood.

- To raise awareness of the impact of additional needs within relationships and the effects on individuals and the increased risk of vulnerability to domestic abuse. This should enable staff to make better-informed risk assessments and safety plans for those individuals.

Hull Domestic Abuse Partnership Domestic Abuse Support Services

- The learning from this whole Domestic Homicide Review process be disseminated to the DAP Domestic Abuse Support Service and reflected upon to consider any improvements to practice that can be made and acted upon.

- For the DAP team to continue to raise awareness of domestic abuse and coercive and controlling behavior and services available.

- The lessons learned from this review are cascaded via training provided by the DAP team, including Safeguarding Adults and Children training.

Humberside Police

- The learning from this case in respect of child protection checks by The Hub, communication of information to attending patrols and appropriate safeguarding to be disseminated force-wide by means of a 'lesson learned' bulletin and recorded on the force action plan.

- Guidance around the use of victimless prosecutions to be disseminated to all front-line police officers and supervisors. This will also be incorporated into the domestic abuse training that is currently being delivered and also into the (Independent Crime Investigation and Development Programme (ICIDP) and Initial Management of serious Crime (IMSC) courses.

Hull and East Yorkshire Hospitals NHS Trust

- Ensure this case study is used as an example in safeguarding training and emphasis and explain the rational for accurate record keeping.

- Staff must ensure that an accurate and comprehensive record is kept of any consultation including the names and relationships of anyone accompanying the patient at the time of the visit.

- Ensure all clinical staff are aware of the need to see the patient on their own at first contact. This would give the opportunity for confidential disclosure. Raise awareness on information sharing, documentation, private consultation and acting in person/public interests.

- Staff know who to contact for advice when they are unsure what to do if the patient is reluctant to access support if offered, specifically relating to Domestic Abuse.

Humber NHS Foundation Trust

- HFT to ensure that clinical staffs in all care groups receive training in the Care Act 2014 commensurate to their area of practice and its application in relation to domestic abuse.

- HFT Safeguarding Adults Policy January 2012 should be reviewed and updated to incorporate guidelines/recommendations of the Care Act 2014.

- The 'safeguarding' section in HFT Mental Health Assessment paperwork should be updated so that adult/child-safeguarding issues can be clearly documented and actions to be taken/completed recorded in line with policy and expected practice standards.

- Hull Secondary Mental Health service operational procedures October 2014 to be reviewed to include a section on discharge procedures to ensure that information sharing where identified as an outcome is achieved and completed.

Hull Clinical Commissioning Group on behalf of The GP Surgery

- Review and update the practice domestic abuse policy and procedure. To include specifics re roles/responsibilities, professional boundaries and support for staff.

- Review the contractual arrangements with ReNew services with specific focus on domestic abuse and violence.

- Improve Systmone clinical notes with implementation of a Prompt/Flag for DA.

- Remind all practice staff of the reporting duties, systems and processes for stolen prescriptions.

- Share lessons learnt from this Domestic Homicide Review process with local GP practices.

ReNew

- Revisit with all agency staff team DV training and signs / symptoms of DV so practitioners could feel more confident in having ' difficult conversations' Revisit current DA & MARAC pathways & paperwork as part of refresher training to ensure both are updated to reflect current policy and practice.

Together Women's Project

- To ensure that all contacts with clients are managed according to current protocol and policy.

- Appropriate information sharing takes place within professionals.

- Risk assessments are completed when contact is made with clients.

Corner House

- Develop and implement a process and protocol for accurate record keeping within the organisation and with staff.

- Ensuring appropriate and timely information sharing is completed and staff are aware of their responsibilities.