Safer Somerset Partnership

Multi- agency Domestic Abuse Death Review

Executive Summary

Into the death of Laura in January 2018

Faye Kamara LLB, MSc
Independent Domestic Homicide Review Chair and Report Author

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1. Preface

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

a) A person to whom she was related or with whom she was or had been in an intimate personal relationship or
b) A member of the same household as herself; held with a view to identifying the lessons to be learnt from the death.

1.2 Throughout the report the term 'domestic abuse' is used in reference to 'domestic violence' as this is the term which has been adopted by the Safer Somerset Partnership.

1.3 The purpose of a DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and agencies work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply those lessons to service response, including changes to policies and procedures as appropriate, and identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.
- Contribute to a better understanding of the nature of domestic violence and abuse;
- Highlight good practice.

1.4 This death was not caused by a homicide, instead death caused by dangerous driving. However, due to the offender being the deceased's current partner it met the criteria for a statutory review. This review examines the circumstances surrounding the death of Laura in Somerset in January 2018 and is called a Multi- Agency Domestic Abuse Death Review. The principles underpinning the review process have been followed in accordance with the Home Office Multi-Agency Statutory Guidance on the Conduct of Domestic Homicide Reviews-Revised Version-December 2016.

1.5 The Independent Chair and the Review Panel members offer their deepest sympathy and condolences to Laura's family. The Chair would also like to thank the Review Panel who have contributed to the deliberations of the Review, for their time, honesty, transparency and cooperation.

1.6 The Chair of the Panel possesses the qualifications and experience required of an Independent Review Chair, as set out in section 5.10 of the Home Office Multi- Agency Statutory Guidance. She is not associated with any of the agencies involved in the Review nor has she had any dealings with either Laura or John and she is totally independent.

2. Multi- Agency Domestic Abuse Death Review Panel

- Faye Kamara LLB, MSc- Independent Chair
- Suzanne Harris, Somerset County Council
- Leanne Rowley, formerly known as Knightstone, now known as Live West from Autumn 2018 (provider of SIDAS- Somerset Integrated Domestic Abuse Service)
- Mark West, Avon and Somerset Constabulary
- Julia Burrows, Somerset Partnership NHS Foundation Trust (SomPar)
- Andrew Tresidder, Somerset Clinical Commissioning Group
- Victoria Wright, Somerset Clinical Commissioning Group

3. Introduction

3.1. This review examines the circumstances surrounding the death of Laura who was 34 years of age and had lived in Somerset for the last few years.

3.2 Laura was a talented artist and a mother to a 12-year old girl called Claire (pseudonym). Laura moved to Somerset in 2016 with her daughter and lived with her mother and stepfather. Laura had a diagnosis of rapid cycle depression and therefore had experienced a very up and down mood for most of her life. Laura also was diagnosed with severe dyslexia when she was 7 years old and therefore found reading and writing difficult even in adult life. Despite these vulnerabilities, family and friends described her as a fun-loving and kind person.

3.3 Laura and John (pseudonym) met whilst Laura was working in a local public house. They became friends at first and then this materialised into a relationship in November 2017. Family members were not happy by Laura's choice and made this clear to her, this was because John was connected, in

the same social circle, to Laura's ex-partner. However, Laura's family described her as being very smitten with John. Claire was introduced to John at the start of the relationship. Family reported as part of this review that Claire had taken a disliking to John and would say to them that 'he is going to hurt my mummy'. It is not completely clear why Claire had these opinions, however it is known that Claire overheard Laura and John having sex one evening in December which may have triggered these opinions.

3.4 In January 2018, it is reported by family members and friends that John had promised to take Laura and Claire out for ice cream in the local town that evening. Time passed into the evening and Laura found out that John had spent his wages in the public house getting drunk. Both Laura and Claire were upset by this and went to visit Laura's mother. Laura's mother offered to have Claire overnight so that Laura could go out and have some fun with friends after her disappointment. It was reported that Laura and John had been seen together that evening in the public house, appearing to be a couple.

3.5 Incident summary:

3.5.1 In the early hours of a day in January 2018 at 2.15hrs the ambulance service called the police to report that they were in attendance of what appeared to be a hit and run incident. A wallet was found at the scene containing a 'males' identity. A van registered to this male was then located with significant front end damage, parked near to Laura's address. The male identified as John of no fixed abode was then later arrested.

3.5.2 Laura was declared deceased at the scene and her mother was notified that evening.

3.5.3 The Coroner opened and adjourned this case in order to allow for the criminal investigation to proceed. The Coroner closed this case at the point of conviction when the defendant pleaded guilty to death caused by dangerous driving and was sentenced to a term of imprisonment and was disqualified from driving.

3.5.4 The police investigated and charged John with murder/manslaughter. However, there was not enough evidence to support this charging decision and therefore this was amended to death by dangerous driving. John pleaded guilty to this offence and was given a custodial sentence for 10 years, reduced to 7.5 years due to an early guilty plea.

3.6 The key purpose of this review is to enable lessons to be learned from Laura's death. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened,

and most importantly, what needs to change in order to reduce the risk of such a tragedy happening in the future.

3.7 The Review Panel consists of senior managers, from both the statutory and voluntary sector, listed in section 2 of this report. All of the agencies who have been part of the Review have assisted in the identification of lessons and committed to implementing action plans to address the lessons.

3.8 The agencies participating in this Domestic Homicide Review are:

- Somerset County Council
- Somerset Partnership NHS Foundation Trust
- Somerset Clinical Commissioning Group
- Avon and Somerset Constabulary
- Knightstone Housing now known as Live West (providers of SIDAS-Somerset Integrated Domestic Abuse Service)
- Taunton and Somerset NHS Foundation Trust

3.9 As per the Home Office guidance a letter together with the Leaflet on 'Domestic Homicide Reviews' was sent to Laura's family, Laura's best friend and John asking whether they wished to engage in this review. The independent Chair has met with Laura's family and spoke with her best friend. John also made contact to understand more about the review via Probation and Prison services. Attempts were also made to make contact with Claire however these proved unsuccessful. Nevertheless, the intelligence from Laura's family and friends has been invaluable in understanding more about the circumstances surrounding this death.

4. Terms of Reference

4.1 Commissioner of the Domestic Homicide Review

4.1.1 The chair of the Safer Somerset Partnership has commissioned this review, following notification of the death (death by dangerous driving) of Laura in the county. The offender was her partner (John).

4.1.2 All other responsibility relating to the review commissioners (Safer Somerset Partnership) namely any changes to these Terms of Reference and the preparation, agreement and implementation of an Action Plan to take forward the local recommendations in the overview report will be the collective responsibility of the Partnership.

4.1.3 The resources required for completing this review will be secured by the chair of the Safer Somerset Partnership.

4.2 Aims of Domestic Homicide Review Process

4.2.1 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.

4.2.2 To produce a report which:

- summarises concisely the relevant chronology of events including:
  - the actions of all the involved agencies;
  - the observations (and any actions) of relatives, friends and workplace colleagues relevant to the review
- analyses and comments on the appropriateness of actions taken;
- makes recommendations which, if implemented, will better safeguard people experiencing domestic abuse, irrespective of the nature of the domestic abuse they've experienced.

4.2.3 Apply these lessons to service responses including changes to policies, procedures, and awareness-raising as appropriate.

4.3 Scope of the review

4.3.1 To review events up to the domestic abuse related death of Laura in January 2018. This is to include any information known about Laura's previous relationships where domestic abuse is understood to have occurred in order to establish whether Laura had been in a pattern of abusive relationships.

4.3.2 Events should be reviewed by all agencies for 3 years (i.e. January 2015) preceding the domestic abuse related death. However, if any agencies have any information prior to that they feel is relevant, then this should also be included in any chronology/IMR.

4.3.3 To seek to fully involve the family, friends, and wider community within the review process.

4.3.4 Consider how (and if knowledge of) all forms of domestic abuse (including the non-physical types) are understood by the local community at large – including family, friends and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control are also fully explored.

4.3.5 Consider how (and if knowledge of) the risk factors surrounding domestic abuse are fully understood by professionals, and the local community –

including family and friends, and how to maximise opportunities to intervene and signpost to support.

4.3.6 Determine if there were any barriers Laura faced in both reporting domestic abuse and accessing services. This should also be explored against the Equality Act 2010's protected characteristics.

4.3.7 Review relevant research and previous domestic homicide reviews (including those in Somerset) to help ensure that the Review and Overview Report is able to maximise opportunities for learning to help avoid similar homicides occurring in future.

4.3.8 Agencies to explore what the response might have been should disclosures have been made by Laura. For example, would the GP practice have been confident to deal with a disclosure of domestic abuse?

5. Schedule of the Domestic Homicide Review Panel Meetings

First Panel Meeting- July 2018

Second Panel Meeting- August 2018

Third Panel Meeting- January 2019

Virtual conversations with Panel members to sign off final report between February 2019-May 2019.

6. Confidentiality

6.1 The findings of this Review are restricted to only participating professionals and their line managers, until after the Review has been approved by the Home Office Quality Assurance Panel.

6.2 As recommended within the 'Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews' to protect the identity of the deceased, and her family, pseudonyms have been used throughout this report.

7. Dissemination

7.1 Each of the Panel members (see list at the beginning of report), and the Chair of the Safer Somerset Partnership have received copies of the Report.

8. Methodology

8.1 The Overview Report has been compiled using information and facts from the following:

- Short factual reports/presentations from the following agencies;
  - Avon and Somerset Constabulary
  - Somerset Clinical Commissioning Group
  - Somerset Partnership NHS Foundation Trust
  - Live West (formerly known as Knightstone) Somerset Integrated Domestic Abuse Service.

- A chronology of events leading to the death of Laura, coordinated and produced by Safer Somerset Partnership

- Discussions during the Review Panel Meetings;

- Conversations with family members and friends of Laura

8.2 Contact was also made by the Safer Somerset Partnership to Bournemouth Community Safety Partnership for information about Laura and Claire when they lived in this area. This was suggested by Laura's family. However, there was very limited information known about these two individuals by the agencies whom form part of the partnership.

9. Analysis

9.1 The Panel has considered the internal reports through the viewpoints of both Laura and John, to ascertain whether the contact made had been appropriate and that the agency acted in accordance with their set procedures and guidelines in order to establish whether any lessons needed to be learnt.

In addition, the reports were to also cover where there hadn't been contact- what would have been the response.

9.2 The authors of the Internal Reports have followed the Review's Terms of Reference and addressed the points within it. The agencies undertook the Internal Reports in an honest, thorough and transparent fashion, ascertaining

information from a number of sources. The following is the Review Panel's view on the appropriateness of the intervention undertaken by each agency and/or whether their policy and procedures are adequate in protecting and supporting victims of domestic abuse.

Somerset Partnership NHS Foundation Trust

9.3 This organisation did not have any contact with Laura. Contact with John was very limited because he chose not to engage. A referral was made by John's GP to the local Talking Therapies service. It is not known why this referral was made because access to John's medical records has not been achieved due to patient confidentiality.

However, it is known that contact was very limited and there was no engagement by John following this referral being made. The referral was incomplete and there was almost a two-week delay in this being followed up with the GP by the Talking Therapies team, and then a further 10 days delay in the additional information being sent to the mental health service by the GP. It was one month after the initial referral was made that attempted contact was made.

9.4 The Panel debated whether the timeliness in John's referral being processed had an impact on this review and concluded that it did not, on the basis that we are unsure how much and why John felt he wanted and needed support from a mental health service. It was reported that self-referrals for Talking Therapies by patients are far more likely to engage than referrals into the service that are made by GPs or other agencies.

9.5 The Panel discussed the referral processes into the Talking Therapies service and agreed that GPs should be reminded of the referral pathway in order to avoid further delay and prevent disengagement with the patient due to time lapsed. This has been actioned as part of a GP bulletin.

Somerset Clinical Commissioning Group

9.6 It was reported within the Internal Report commissioned by the Independent Chair and by the author as part of the Panel meeting that Laura had registered in Somerset with the GP practice only at the end of 2015 and therefore there was minimal information.

However, during the two years Laura had a number of contacts with the GP; some for physical health concerns; sore throat etc. and there were two consultations' in quick succession where Laura disclosed issues with her mental health and was proactively seeking support, advice and help from the

GP. There was one consultation where she did disclose historical abuse however there is no evidence in her records that her current relationship status was explored. The Panel felt that professional curiosity is something that should be added as a recommendation for all healthcare staff and be included in safeguarding training.

9.7 The Internal Report highlighted these two contacts, both of which occurred in the summer of 2016. The Panel debated whether it was deemed appropriate to give a patient with severe dyslexia a leaflet for a service they needed and the onerous on them to make the referral themselves. The Panel accepted that there is a greater engagement rate where patient's self –refer, and the Panel felt assured that the leaflet was in easy to read format. Nevertheless, this did also trigger another learning point, in that the GP supporting and treating Laura in Somerset did not appear to know Laura's history from previous GP surgeries where she had disclosed periods of low mood and suicidal thoughts before.

Laura's records indicate that the information surrounding her dyslexia were not available and therefore it is highly likely that the Somerset GP was not aware of this learning difficulty. Clinically the diagnosis was debated by the Panel also because there was no 'flag' on Laura's records or history. There was only one mention of this in a mental health assessment which was undertaken when she was a child.

Therefore, the Panel concluded that due to multiple GP practices caring for Laura over the years, the information in her history was not successfully transferred between GP practices in succinct summary form in order to support a new GP in their role of providing care to her as a new patient. Had this been the case then perhaps greater intervention would have been offered for Laura upon these two attendances by the GP. This short summary would have to have been initiated by Laura though because this is not routine practice and unless the patient advises the current GP that they intend to register elsewhere they will not be aware of such change.

9.8 It is clear from the contact Laura had with the GP practice that this was empathetic and supportive. The Panel questioned whether a PHQ-9 form had been undertaken upon her attendances reporting low mood in order to track her feelings of depression and anxiety. This questionnaire is a tool used in primary care called Patient Health Questionnaire 9 item, in order to establish the presence and severity of anxiety and depression.

This is not a mandated action on GPs when a patient discloses feelings of this nature, however is a resource available to them. The Panel felt in this case that it was not a missed opportunity that one was not completed with Laura,

however a follow up appointment to see how Laura was feeling after her second attendance in August 2016 would have been good practice.

Avon and Somerset Constabulary

9.9 This Internal Report was undertaken using a range of methodologies to research for information about both parties during the three-year period as per the Terms of Reference. Very limited information was held about either party until the incident in January 2018. The internal report was transparent, and actions taken in relation to the aforementioned incident were critiqued well.

Consideration was given to the contact this organisation had with John because there had been a previous domestic incident reported to the police by an ex-partner of John. This incident involved damage to their jointly owned car and was correctly identified as a domestic incident and treated as such. Unfortunately, there was little cooperation by either party in order to complete a DASH Risk assessment nevertheless the intention was there to undertake this. The Panel agreed that these were appropriate actions and that an analysis of the previous domestic incident was entirely reasonable.

9.10 The actions undertaken by this organisation after the fatal incident resulting in Laura's death were also analysed as part of this review. The Internal Report and Panel both agreed that actions undertaken to investigate how Laura died were robust and reasonable. Appropriate procedures were initiated following attendance at the scene and priority enquiries were progressed around identifying the victim and notifying the family as well as identifying and arresting the offender. The family also supported this comment that Avon and Somerset Constabulary investigated Laura's death well.

9.11 Another line of enquiry which was explored by this organisation related to Laura's involvement with any other police forces because it was reported by her family that she had been in a number of abusive relationships some of which had had police involvement; this was carried out with respect to the Terms of Reference in para 8.4.1.

One domestic incident was reported to another police force in 2012 by Laura. She reported that she was being harassed by her ex-partner, whom she also added had been abusive to her during the relationship also. Policies and practices have changed and much improved since 2012 therefore the actions taken were not analysed in great detail. However, the Report Author and Police representative felt that this incident was dealt with appropriately; a DASH completed in a timely manner, an harassment warning issued and a follow up conversation was had with Laura 6 weeks after the initial report to

see how she was and whether she had received any contact from the person in question.

9.12 This organisation did not make any recommendations as a result of this review. Their policy and procedure had recently been reviewed following another domestic homicide review and the Panel felt assured that this reflected all of the latest guidance, research and legislation.

Somerset Integrated Domestic Abuse Service

9.13 This organisation did not have any contact with either party. The Panel were keen to understand more about the prevalence rates of domestic abuse reported incidents/referrals into this service within the area where Laura lived. This district was the third highest rate of referrals compared to the other areas that make up the county of Somerset. Staff working for this service were asked as part of this review to comment, using their professional knowledge, on whether there were any agencies within the district where Laura lived whom required domestic abuse awareness training. They concluded by advising that all agencies were working well together in this district to reduce the harm caused by domestic abuse and that no additional domestic abuse awareness training was necessary.

9.14 There was one theme which was discussed by the Panel. This was the unfortunate pattern of abusive relationships which Laura had with various males during her lifetime. Her family advised, as part of this review, that she was a vulnerable individual owing to her mental health and lack of confidence and seemed to attract the same kind of person. The Panel discussed how perpetrators of domestic abuse can sometimes spot these signs in individuals and the relationships become abusive because they like to exert their power and control on the person who is vulnerable. This appeared true for Laura.

According to Laura's family she also did not have a high level of self-esteem because they felt this had been torn down by her previous abusive partners. It is true that someone who has had their self-worth taken away is more likely to believe they deserve what their partner chooses to do, or that they are so unlovable, no healthy partner will ever want them (The National Domestic Violence Hotline, 2019). As already highlighted it is sometimes the case that perpetrators can recognise this trait.

The Panel therefore concluded how important it is to raise awareness of domestic abuse and the impact abusive relationships can have on self-confidence for the short and longer term.

10. Conclusions

10.1 In reaching their conclusions the Review Panel have focussed on the following questions;

- Has the Panel fulfilled the Terms of Reference for this review by undertaking a variety of lines of enquiry, including discussing the drat chronology and entering broader more strategic discussions about cross authority working?
- Will the actions and suggestions for improvement improve the response domestic abuse victims have in the future?
- What are the key themes or learning points from this review?

10.2 The Review Panel are satisfied that the Terms of Reference have been fulfilled and that discussions did take place at the Panel meeting to consider what was known prior to Laura's death in January 2018.

10.3 The Panel is of the opinion that the agreed recommendations appropriately address the points raised throughout the review, particularly in relation to the lessons learnt and the theme discussed.

10.4 The Panel felt that there were a number of key issues which were fundamental to the discussion and therefore key learning points. Firstly, the fact that Laura's mental health history was not available and therefore could not be taken into consideration by the GP because it was not included in a short summary as a new patient and her medical records had not arrived at the Somerset practice.

This meant that a strategic position and her chronological history was not available to be explored when she attended the practice with low mood and anxiety. The Panel accept that this would not have prevented her death however it might have helped how she felt in terms of wellbeing, support networks and her confidence and how the GP supported her moving forward.

10.5 Another key discussion point related to the pattern of Laura's abusive relationships according to her family and how society can best support those who continue to enter into these. Consideration was also made on how services should be in place for perpetrators to help break the cycle of abuse. As a county Somerset have a strong domestic abuse partnership which consists of a range of agencies whom work together to improve the responses to victims of domestic abuse. The Panel, as representatives of this partnership,

reflected on how well they are trying to raise the awareness and educate society about abusive relationships. This led to an agreement that more could be done to raise awareness and combat the patterns that vulnerable individuals enter into of one abusive relationship after another. Also, there should be improvements in how abusive behaviour should be identified, challenged and support be in place for those perpetrators needing help to change their behaviour.

Laura's family also overtly have asked as part of this review if there could be more awareness of what support family members can offer their loved ones whom they believe are in abusive relationships. Somerset County Council through their "Somerset Survivors website" noted that they have produced a 'family and friends' booklet' which offers advice to family and friends who suspect their loved one maybe in an abusive relationship.

11 Recommendations

11.1 NHS England with support of Somerset Clinical Commissioning Group

11.1.1 Discussion to be had, with the assistance of the Chair of this review, regarding medical records and how high-level medical history can be shared with a new GP practice as soon after registration has taken place in order to ensure the continuation of the patient's care appropriately.

11.2 Safer Somerset Partnership

11.2.1 Consideration to be given to an awareness campaign focusing on the pattern of abusive relationships and how individuals can access support to end this cycle of one abusive relationship after another. (It was suggested by the Panel that this could be the theme for Domestic Abuse Awareness Week in November 2019)

11.3 Somerset Integrated Domestic Abuse Service

11.3.1 This agency, with the support of the domestic abuse partnership, to raise awareness of their services for family members and friends whom are worried about their loved ones being in an abusive relationship. And to promote the availability of the 'family and friends' booklet' at www.somersetsurvivors.org.uk.

11.4 Additional Panel recommendations

11.4.1 Safer Somerset Partnership to lead in supporting the Safeguarding Somerset Adult Board to disseminate the learning from this review to all agencies involved in safeguarding vulnerable people.

11.4.2 Safer Somerset Partnership in support with the Domestic Abuse Board to seek assurance in asking all agencies to provide evidence that they include professional curiosity in their safeguarding training. This is in particular the exploration of an individual's relationship status when there is any disclosure of abuse; historical, recent or current.