DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

REPORT INTO THE DEATH OF ADULT FEMALE CD on 5th July 2011

Report produced by North Somerset People and Communities Board

20 June 2014

1. Introduction

This Executive Summary of a Domestic Homicide Review (DHR) provides a brief overview of the full DHR report regarding CD, a resident of North Somerset.
The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence.

2. The Review Process

Circumstances leading to the Review

This review was commissioned by North Somerset People and Communities Board on 27th July 2011 following the unexpected death of CD on 5th July 2011 and the arrest of her husband EF who was charged with, and subsequently convicted of, her murder.

Timescales and Methodology

This review originally began on 18th August 2011 but was then delayed until the conclusion of criminal proceedings. The process was completed on 21st November 2012. Independent Management Reviews (IMRs) were commissioned from Avon and Somerset Constabulary, the perpetrator's GP and an independent counselling agency.

Delays to the final report were caused by contact with EF and in order to allow contact with the family of CD and their input into the process. However, implementation of the recommendations arising from the IMRs and analysis were not delayed.

DHR Panel Members

Cathy Morgan Independent Chair
Jo Mercer CSP CSDAT
Amy Hurst CSP CSDAT
Louise Branch CSP CSDAT
Leanne Pook Police Public Protection Unit
Kim Forey NHS North Somerset
Heather Stamp Chapter 1 (IDVAs and Gemini Refuge)
Sally Morrissey People Can (Alliance Homes)

3. Confidentiality

This report is anonymised to ensure confidentiality in relation to the perpetrator and victim and their families. However it should be acknowledged that this is within the context of the perpetrator having gone to public trial and being convicted of murder, resulting in reports in the local press.

4. Key Issues

- The problems between CD and EF were largely 'hidden' and neither party sought formal help regarding their relationship difficulties.
- There was very little agency involvement with either party.
- Use of alcohol was a feature in this case and this put CD at greater risk of harm.
- Some concerns were raised about access to confidential information from third parties, such as GPs and private counselling agencies, due to confidentiality issues.

5. Lessons Learned and Recommendations and Actions

There are lessons to be learned from this death and these have informed a series of recommendations which focus on the need to:

- Raise the awareness of victims of domestic abuse so that they identify it and the support that is available to them
- Raise friends, families and employers' awareness of domestic abuse and the support available
- Raise professionals' awareness of domestic abuse, the support available and how to risk assess and support service users experiencing domestic abuse
- Improve GPs' responses to domestic abuse and their interaction with counselling agencies

Organisation	Recommendation
North Somerset People and Communities Board (Community Safety Partnership)	Continue to raise awareness and encourage reporting of domestic abuse and in particular promote domestic abuse campaigns directed at members of the public for third party disclosure.
	Focus on family and friends noticing signs of domestic abuse and reporting to relevant agencies (not necessarily the police)
	Consider a wider range of methods to get domestic abuse messages across including radio/TV/public transport adverts; Facebook/Youtube/Twitter and a domestic abuse theme for the Google homepage

	Address self-denial in professional people
	Encourage employers to consider and engage in Domestic Abuse policies for their staff
	DASH risk assessment – promote use of this by GPs and private counsellors to identify risk and consider use of it by family/ friends of people at risk
North Somerset CCG	Ensure GPs are required to receive training and regular updates on domestic abuse and to look for signs, risk assess and share information regarding domestic abuse
	Consider how to support GP practices in conducting IMRs following a Domestic Homicide
	Ensure that agencies who are contracted by the NHS have clear discharge summaries back to the referring GP
	Review current counselling contracts with the NHS and ensure that private counsellors are given a general issue duty of care for their clients
	Engage and encourage private counsellors to disclose domestic abuse
	Determine boundaries between domestic abuse and adult safeguarding issues
Home Office	Highlight procedure for the situation where one of the agencies is aware of information held by another agency which is not disclosed to the wider group – in particular in relation to patient confidentiality or private counselling confidentiality issues
	Consider introducing guidance on how small organisations and GP practices can conduct Independent Management Reviews in an independent and quality assured way