DOMESTIC HOMICIDE REVIEW
FULL OVERVIEW REPORT

REPORT INTO THE DEATH OF ADULT FEMALE CD on 5th July 2011
Report produced by North Somerset People and Communities Board

20/06/14

1. Introduction

1.1 Background

This report of a Domestic Homicide Review (DHR) examines agency responses and support given to CD, a resident of North Somerset prior to the point of her death on 5th July 2011.

The review will consider agencies contact/involvement with both CD and her husband EF from 2001 until CD was found dead at her home on 5th July 2011. 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. In order for these lessons to be learned as widely as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.2 Circumstances leading to the Review

This review was commissioned by North Somerset Community Safety Partnership (CSP) 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 her murder.

It was clear from the outset that CD had not disclosed domestic abuse to any agencies and had very little agency contact at all. She had spoken of some aspects of domestic abuse to individual friends, colleagues and a family member over a period of time but had not given anyone a full picture of what she was living with. This lack of contact with CD severely limited the scope of the review and its ability to clarify the details of her experiences in the time leading up to her death. Nevertheless it was felt that a review should be held as it was agreed by the CSP that the case met the requirements for undertaking a Domestic Homicide Review (DHR). After preliminary meetings with relevant agencies it was agreed that the DHR needed to be postponed until after the case had gone to trial and the outcome of this was known.

1.3 Timescales and Methodology

This review originally began on 18th August 2011. There was then an agreed delay in the process due to the need to wait until criminal proceedings had been completed. The process recommenced on 23rd May 2012 and 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. These reviews were received by 14th November 2012 which is within six months of the recommencement of the review.

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.

The Overview author has had access to the combined chronology and the agency IMRs, and has had discussions with IMR authors and Panel Members. Reference has also been made to relevant national information about domestic violence and to local information available to the public about domestic abuse and domestic violence both through the CSP (via CSDAT) and locally commissioned agencies.

The panel took the decision that police officers who had already established a relationship with CD's friends and family members should contact them on behalf of this review. The officers used a set of questions agreed by the panel as a guide to discussions. The benefits of this approach included:

- The witnesses and police staff were known to each other and were more at ease with the process.
- Police staff used had access and good knowledge of the statements provided by the witnesses.
- In particular witnesses commented that they welcomed the presence of the police staff used in the review process.

The findings from these discussions are summarised in section 7 – views of family and friends

The scope of the Terms of Reference of the DHR was limited due to the lack of contact with agencies. Therefore, the Terms of Reference stated that the aims of the review would be to identify:

- Lessons which can be learned with regard to provision of information about domestic abuse support available in North Somerset
- Any lessons which can be learned around the connections between domestic abuse and mental health issues and domestic abuse and alcohol issues.
- Any other relevant facts or information

1.4 DHR Panel Members

Cathy Morgan was appointed as Independent Chair. She has extensive experience in mental health social work and is a former Director of Health and Social Care for Bristol City Council. She was therefore felt to have the necessary experience of safeguarding, domestic abuse and social care issues. She also has experience of writing Serious Case Reviews and had no work connections with North Somerset council or any agencies.

Cathy Morgan Independent Chair

Jo Mercer CSP CSDAT Manager
Amy Hurst CSP CSDAT Crime Co-ordinator
Louise Branch CSP CSDAT Domestic Abuse Co-ordinator
Leanne Pook Police Public Protection Unit Detective Chief Inspector
Kim Forey NHS North Somerset
Heather Stamp Chapter 1 IDVAs and Gemini Refuge Manager
Sally Morrissey People Can Regional Manager

2. Confidentiality

Information used in this review was obtained with the consent of the individuals and agencies who gave it.

The contents of this review are confidential to the DHR Panel. Information is only available to participating officers and professionals and their line managers. The report has been anonymised so that individuals cannot be recognised. However it should be acknowledged that this is within the context of the perpetrator having gone to public trial and been convicted of murder, resulting in reports in the local press. A summary version of this report which includes the main findings and recommendations will be prepared for wider dissemination and publication.

3. Dissemination

Copies of this report have been received by the following agencies:

- North Somerset People and Communities Board (encompasses Community Safety Partnership)
- North Somerset Safeguarding Adults Board
- Avon and Somerset Constabulary
- North Somerset Clinical Commissioning Group (CCG)

4. The Facts

4.1 Circumstances of the Murder

1. CD lived with her husband EF in a rural area of North Somerset. They did not have any children. On 5th July 2011 the police were called to her home by CD's brother who had found her dead on the living room floor. She had suffered multiple injuries to her head and torso.

2. There had been no police involvement with either the victim or the perpetrator prior to CD's death. When the police attended EF was attempting to set the house alight and then jumped out of the window and fell onto the road. He was taken to hospital and later arrested and subsequently interviewed. He denied murdering his wife but reported they had had an argument as she wished to end their relationship. He said that he flew into a rage and lost control, culminating in him picking up a hoover pipe and hitting her about the head several times. He believed she had died on 3rd July.

3. A Post Mortem was carried out and established the cause of death as being a severe and sustained attack causing significant head injuries as well as other injuries.

4.2 Chronology of the Marriage and Relationship

The information set out below expands on the information contained in the chronology through the inclusion of information from third parties (including friends, relatives and work colleagues) who were interviewed by the police during the investigation. Third parties who CD spoke to including relatives and work colleagues are referred to throughout the report and chronology as 'friends' to further protect their anonymity.

1. CD and her husband had met initially through a dating agency around 2000/01. Reports from people who knew the victim stated that between 2001 and 2003 CD had reported problems in the relationship to friends and said she had been 'thumped' by EF on one occasion. She had also been seen with a black eye but when asked about it she attributed this to being caused by an accident with a horse (she was a keen horsewoman).

2. On 31st July 2003 EF went to see his GP for a prescription for a gastro-intestinal disorder. He reported having 'two weeks ago got drunk and trashed the place, cut his foot and assaulted his girlfriend'. He said he had been 'almost dry' since then although he was not sure that alcohol was a problem. His GP advised him to remain teetotal, which EF agreed to. (Note: this may be the same event that CD had reported to a friend as recorded above).

3. CD and EF were married in September 2006 and CD retained her maiden name. The home they occupied was inherited by CD on the death of her father. It was at the rear of a shop belonging to the family which was inherited by another family member. CD had worked for a Veterinary Practice since 1998. EF had been unemployed for a number of years and after their marriage carried out renovations at their home and adjoining properties.

4. CD remained unhappy and in 2006 following the marriage CD wrote to a friend of EF with her concerns about him but did not receive a reply. Also in the same year CD reported to a friend that EF had hit her. CD was reported to be shocked more than upset. CD's friend had no further details about this incident.

5. Between May 2007 and July 2010 EF consulted his GP regarding his mood. He was initially sent in to see his GP by his wife and he told his GP of his previous counselling and family history of suicide. He was thought to suffer from depression and it was recorded that he related the onset to his recent marriage. In May 2007 he was referred to a counselling service and his GP suggested that he could also contact Relate (a couple and marriage counselling agency) but there is no information regarding this suggestion being followed up.

6. EF was prescribed medication which he initially felt was not helping. In June 2007 he told his GP that when he forgot his tablets for 6 days his wife noticed the difference. He was encouraged by his GP to continue the treatment. In January 2008 he

admitted poor compliance with his medication and by June 2008 he had stopped his medication and reported feeling great but with some sleep problems, and said he was working non-stop 12-16 hours daily. His GP discussed with him cyclical depression and manic features.

7. EF was referred to a counselling agency and saw a counsellor regularly between January 2008 and September 2008. In January 2008 EF told his GP that he felt the counselling was not personal enough for him and his GP advised him about web services he could use to seek help.

8. EF continued to attend counselling sessions and received Cognitive Behavioural Therapy (CBT). He had initially been referred for six sessions but he requested a need to continue and the agency agreed to extend his sessions. He received a total of seventeen sessions. The counselling agency recorded that EF had problems managing his anger and he was considered to be a high risk patient, but that he was no longer regarded as high risk when his contact ended.

9. In 2009 (approximately) it was recorded that there was a fight when EF attacked CD and had his hands round her throat. CD was upset and told her friend that she had to hit him with a frying pan to get him off. No injuries were seen on CD at that time.

10. In June or July 2009 CD wrote to a friend of EF's about the difficulties in their marriage. She was unhappy about EF's mental health and frightened when he had been drinking. She said he was abusive and drinking excessively but could also be caring and attentive towards her. EF was contacted and advised to return to see his GP.

11. In February 2010 CD spoke to a friend – she was crying and disclosed that EF was violent and had thrown a chair at her a few days previously.

12. In March 2010 EF was seen again by his GP regarding his depression, of which there was a long family history. It was noted he had had previous Cognitive Behavioural Therapy (CBT) and he was offered web addresses and a self-referral for counselling was suggested. He was also prescribed the anti-depressant medication Sertraline 100mg between March and July 2010. By May 2010 EF reported to his GP that he was improving, that he was taking his pills and doing web/reading homework.

13. In May 2010 CD told a friend that EF was suffering from depression and had been violent towards her on more than one occasion.

14. In July 2010 EF told his GP that he had completed 3-4 months of his Sertraline medication but had been taking it more irregularly as he was 'always better at this time of year'. A discussion was held about weaning off, recurrence and preventive measures, and he was given a final one month prescription.

15. In the autumn of 2010 CD was seen walking looking ‘stiff and sore’ and stated to a friend she had been knocked over by a dog when out running and would be ‘battered and bruised in the morning’.

16. In 2011 CD advised a friend that EF had disappeared for 4 hours on her birthday (not for the first time) and that he was drinking a lot recently.

17. A friend who was aware of the previous assault by EF reported in a witness statement that in June 2011 (approximately) the relationship between CD and EF was not good.

18. On 1st July 2011 CD attended work for the last time.

19. On 2nd July 2011 in the evening a friend who was aware EF was suffering from depression called CD and arranged to meet her the next day. When CD was asked how things were between her and EF she replied ‘bad’.

20. On 3rd July the above friend called at CD’s home as arranged but got no reply.

21. On 4th July 2011 the veterinary surgery tried to call CD on the telephone at home to find out where she was as she was due in to work – EF answered and said she was unwell and would not be coming to work.

22. On 5th July 2011 CD’s brother found her dead at home and the police were called.

23. EF was arrested and subsequently charged with murder. On 9th January 2012 he was found guilty of murder and sentenced to life, with a minimum of 13 years in prison.

4.3 Summary of Agency and Professional Involvement

1. As can be seen from the chronology, the victim and the perpetrator had very little contact with external agencies. CD had no direct agency contacts as far as is known, and there was no record of her seeing her GP during this period.

2. EF had regular contact with his GP and with an independent counselling agency. EF had revealed one episode of violence towards his girlfriend to his GP in 2003 (this is presumed to be CD as they were in a relationship at that time but not yet married) but there is no record of this information being communicated to others. There were no further disclosures regarding violent behaviour made to the GP.

3. EF received help from a counselling agency in the form of Cognitive Behavioural Therapy (CBT). He was initially referred by his GP for 6 sessions but these were extended to a total of 17 sessions. The agency report described him as someone who had problems managing his anger and he was considered to be a high risk at the start of this therapy. He was not considered to be a high risk when his therapy ended and there is no mention of any risk he may have posed specifically to his wife.

The counselling agency was not aware of the episodes of physical abuse that CD had reported to friends, nor of the disclosure that EF had made to his GP.

4. EF also saw his GP regularly and received treatment for depression in the form of medication as well being referred to the counselling agency. EF did speak to his GP regarding problems in his marriage and he was recommended to contact Relate but there is no record that he did so. The GP reported he could see no risk to CD from his contact with EF and he was more concerned about the potential risk of suicide for EF.

5. CD did not have any contact with external agencies as far as is known and there are no records from her GP covering this period. However she did speak to others (family, friends and colleagues) from time to time regarding her concerns about EF who she reportedly wished to help, and also her concerns about his at times violent behaviour, particularly when he had been drinking.

6. CD did not disclose to anyone if she was trying to leave EF at any point before her death.

5. Views of Perpetrator EF

1. An interview was held with EF to establish whether any lessons could be learned or recommendations made to improve agency responses.
   EF said that as he had suffered a head trauma at the time of his arrest his memory around the time of the actual event and the two or three weeks preceding the event was patchy.
2. In respect of his relationship with his wife CD he said that he felt they had a pretty good relationship and did not argue very much. He said he felt hitting anyone was totally wrong and he is not a violent person, but a passive person. Prior to the event leading to CD's death EF said he and his wife never had many arguments but did sometimes argue about other family members. He was not concerned that arguments might get out of control. He confirmed that he had hit her on two occasions, once when he gave her a black eye, and he confirmed the incident where he had put his hands round her throat. He said he did not throw a chair at her in February 2010 as she had reported to a friend. He confirmed the incident where she had been knocked over by a dog and been bruised.

3. In respect of EF's drinking he did not feel it was a problem. He felt he had been depressed for which he had been receiving treatment. He would have two or three beers before a meal and some evenings would not drink at all. He drank four or five nights a week. He said that sometimes they argued when he had been drinking but the drinking was not the cause of the argument. EF said he had never got into a fight due to drink. His wife had told him he seemed to be drinking a lot more so he stopped for five weeks to show he could do without alcohol. He used to enjoy a drink at home. He did not feel he needed help with his drinking; he mainly drank beer, not spirits.

4. From 2001 EF felt he needed help with his depression. He lacked confidence and did not want to do anything. He did not really understand the CBT treatment and felt it helped only a little bit. With regard to the high risk regarding anger management,

he said that the first time he saw the counsellor he was stressed due to circumstances including a flood and a meeting he was due to attend. His anger usually turned on himself; he was more likely to beat himself up than anyone else. Sometimes he was frustrated at the sessions due to the long journey and being late. He said the trigger for his depression came from the difficulty he had adjusting after moving to the UK from South Africa as a young man. He had a very heavy workload. He had problems with depression prior to meeting CD.

5. On the day of CD's death EF was not feeling well and had felt unwell for a few days. He was depressed and upset and left the house and went into town and got something to eat. He was no longer on medication for depression and he was feeling frightened. After he returned home he and his wife got into an argument, she wanted to know where he had been and accused him of having an affair. He felt petrified, the next thing he remembers is his wife was dead and he had the hoover pipe in his hand and he realised he had killed her. He could not think of anything that would have made a difference as he does not know how the attack started. He did not call anyone as he planned to commit suicide. He went out to the supermarket and bought alcohol and tablets and took them when he got home.

6. EF could not identify any lessons learned, or how the death may have been avoided as he did not know why it happened. He was not on medication at the time and did not know how unwell he was. He cannot come to terms with what he has done and will have to live with it.

7. EF could not identify any agency actions that would have made a difference to the outcome as from his perspective it was unpredictable. He and his wife had argued before but always showed remorse and made up afterwards. He said that even if he had gone to his GP to get help with medication it might not have prevented the death as it was an argument like nothing before.

6 Analysis

1. A significant theme in this case is that neither party sought help regarding difficulties in their marriage. Although CD mentioned concerns to friends about her husband's temper and violence towards her on several occasions, as well as his excessive drinking, she did not appear to wish to seek out more formal help, and friends reported that she was mainly concerned about EF and wished to help him with his depression. CD married EF in 2006 in spite of the fact that there had been earlier problems in their relationship that included at least one known incident of EF hitting her. EF told his GP that there were problems in the marriage but did not follow up the suggestion that he and his wife could seek help from an agency such as Relate. EF did reveal one episode of domestic abuse to his GP in 2003 but did not ask for specific help and there were no suggestions made for follow up. EF did not reveal any further episodes to his GP nor to his counsellor, although his counsellor did state that he had problems with anger management and that he was considered to be a high risk at the start of his therapy. A reference was made by the GP to EF's heavy drinking in 2003, and CD also made comments to friends about her husband's drinking.

2. The lack of agency involvement and specific knowledge in this case is not uncommon in situations where domestic abuse and violence takes place. Information from research into domestic violence published by Women's Aid shows that it can affect more than one in four women in their lifetimes, regardless of age, social class, race, disability or lifestyle, and accounts for between 16% to 25% of all recorded violent crime. Significantly research also shows that abusers typically display different kinds of behaviours in public than they do in their private relationships, and most people are not usually aware of domestic violence when it is happening in their community. This can make it more difficult for women to reach out for support.

3. In relation to people who abuse alcohol or related substances, although this is not felt to be an underlying cause of domestic violence, it is important to note that a study of 336 convicted offenders of domestic violence found that alcohol was a feature in 62% of offences and 48% of offenders were alcohol dependant (Gilchrist et al, 2003).

4. Findings from the self-completion module of the 2001 British Crime Survey (Walby and Allen 2004) also show that injuries were often sustained as a result of domestic violence, with 46% of women sustaining a minor physical injury, 20% a moderate physical injury, and 6% severe injuries.

5. Information about why abused women do not leave their partners cites a number of reasons including the victim still caring for her partner and hoping he will change, or feeling ashamed about what has happened and believing it is her fault.

6. With the benefit of hindsight, this information illustrates that there were signs that were typical of domestic violence in relation to CD's comments to friends about her concerns about EF's temper and his drinking, as well as the fact that she spoke of occasions when he had been angry and violent and had hit her or threatened her. She was also reported by friends to have suffered some minor injuries on at least two occasions, (although she did not attribute these to her husband).

7. It seems unlikely that any single person known to CD had heard the full story of the abuse that she had suffered, thus reducing the chance that her family or friends would notice any particular pattern or significance in her disclosures. Family and friends may also have had reservations about becoming involved in the situation for fear of making matters worse than they already were. Evidence shows that leaving an abusive relationship does not guarantee that the violence will stop, and that the period when a woman is planning or making her exit is often the most dangerous time for her (Women's Aid Domestic Violence: Frequently Asked Questions Factsheet 2009). There is no indication that CD was advised to seek specialist help from domestic abuse or marriage counselling agencies. What is known is that according to her friends and family she was concerned about her husband and wished to support and help him.

8. As already noted neither CD nor EF sought specific help regarding their marital difficulties and it is difficult to know if either party knew of or wished to seek help from agencies that could have offered support to either or both of them. It is known that EF did not use his counselling sessions to discuss his marital problems and did not follow up his GP's suggestion to contact Relate. It is not known if CD would have wished to seek help or whether she or her husband knew where to seek help if they had wished to. Although CD made some disclosures regarding EF's behaviour, she did not specifically ask for help and in retrospect it seems likely that she may have made excuses for minor injuries she suffered which may have been due to domestic violence.

9. Although it is not known if CD knew where to seek help regarding the abuse she was suffering if she needed it, a summary of local services for domestic violence and abuse in this area shows that local information about domestic abuse is readily available and easily accessed through the local authority website and independent agencies, and includes weekly information in the local paper. The last Crimestoppers campaign took place in 2009 and leaflets for a campaign to highlight the links between abuse of animals and domestic abuse were sent to all veterinary surgeries, and CD would almost certainly have seen these.

10. Could different decisions have been made or actions taken in this case that could have changed the outcome? CD was described as a private person with no close friends, and although she disclosed some incidents to friends over a period of time she did not ask for specific help nor she did not seek support from her GP. She was also reported to want to help and support EF with his depression as is evidenced by her encouraging him to seek help from his GP, which did seem to lead to some improvements in his mood. EF did reveal one episode of domestic abuse towards his wife to his GP in 2003 but did not reveal to any other third parties the incidents of abuse as far as is known. No action was taken following this disclosure to his GP but it is possible that if the GP had been more pro-active in responding to this disclosure (e.g. by suggesting where EF or his wife could seek help), that it could have affected the outcome. The abuse continued for some years after this before leading to CD's death, thus not responding to this disclosure can be seen as potentially a significant missed opportunity, although it is not possible to say how this would have affected the outcome. At the same time, although there were some concerns expressed by CD's friends at different times, actions were not taken. It is likely that the potential seriousness of the situation was not realised and also that if consulted CD would not have wished action to be taken. She had stated her wish to continue to help and support her husband, but she may also have been frightened of how he might respond if he knew she had talked to others about his behaviour.

11. CD herself may not have realised the seriousness of the risk to her, with the comment being made by a domestic violence worker that 'she probably did not believe she would be killed'. Evidence shows that abused women stay with their partners for a variety of reasons, including caring for their partner and hoping he will change; feeling ashamed about what has happened and believing it is her fault;

feeling exhausted and unable to make decisions; and not knowing where to go (women's aid: ibid).

12. It is possible that if CD had decided to seek formal help, either with or without the support of friends, that her death could have been avoided. However a confrontation about this between her and EF could also have increased the risk to her, particularly as EF was prone to heavy drinking and had not shown any wish to reveal or acknowledge his use of violence towards his wife, although he had opportunities to do this both with his GP and with his counsellor.

13. In carrying out this Review some issues and concerns were raised about access to confidential information from third parties such as GPs and private counselling agencies due to commitments made to individuals about confidentiality. Although this was not felt to have been highly significant in this particular case, there were concerns that this might have been the case and this particular lesson learned has been addressed in the recommendations of the report.

7 Views of Family and Friends

CD's family, friends and work colleagues were spoken to as part of the investigation following CD's death, and nine people including one member of both CD's and EF's family were identified as having information relating to domestic abuse.

CD's mother had not been told by anyone (including CD) about any abuse and was unaware of the abuse her daughter was suffering.

All CD's friends and relatives were shocked and upset by her death and questioned themselves as to whether if they had done more she would still be alive.

The information gathered shows that CD had disclosed some information to different people at different times as set out in the report. CD was described as 'a private person' and as 'a strong, quiet person' who did not directly ask for help and continued to say that she wished to support and help her husband. One person stated that CD 'never appeared frightened'. She had also told friends that EF 'could be caring and attentive towards her'.

At least two people at different times advised CD to look for somewhere else she could go including a refuge for abused women, but CD did not follow this up. Most of CD's friends did not know or understand the definition of Domestic Abuse and were not aware of where to seek advice.

There was a general consensus that more awareness and education about domestic abuse should be available in schools, in GP surgeries and in the workplace, and one comment that a 7 day a week 24 hour helpline for women to call would be helpful.

8 Conclusions

1. This case is characterised by the relatively 'hidden' nature of the abuse and the unwillingness or inability of the both the victim and the perpetrator to fully reveal their difficulties or to seek formal help with the specific issue of domestic violence. There had been no prior contact with the police before the homicide occurred, and no

disclosure to either the victim's GP or the perpetrator's counsellor. The perpetrator had made one disclosure to his GP in 2003, but this was not followed up and no further disclosures were made in spite of regular contact between EF and his GP. As already noted, it is not unusual for the victim to stay with the perpetrator in spite of his violent behaviour, hoping that she may be able to help him or that he may change. This case highlights the vital importance of continuing to raise awareness about domestic abuse, not just for friends and family members of victims, and for work colleagues, but for the victims themselves. For example a reluctance to seek help may be tempered by information about the potential risks to the victim of serious injury or death. It is crucial that people understand that they can seek help without recrimination and without pressure to reveal identities, as this may lead to an earlier disclosure of problems. However although these services are available there are still significant barriers to overcome for those needing help or their family and friends. There are lessons to be learned from this case and recommendations for action to improve or enhance local and national service provision in the areas of domestic violence and abuse as a result. It is to be hoped that these recommendations will help to further reduce risks and increase the safety of those women who are currently subject to domestic violence or or those who may be in the future.

DHR1 Recommendations and Actions

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

9 Good Practice

Organisation	
Avon and Somerset Constabulary	Important information in this case was held by members of the public who knew the victim rather than by agencies. These interviews were carried out with particular sensitivity and skill by an experienced female police officer.

Appendix 1 – Home Office approval

Safeguarding & Vulnerable People Unit
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Ms Louise Branch
Domestic Abuse Co-ordinator
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BS23 1UJ

06 October 2014

Dear Ms Branch,

Thank you for re-submitting the Domestic Homicide Review (DHR) report from North Somerset to the Home Office Quality Assurance (QA) Panel.

The QA Panel would like to thank you for conducting this review and for providing them with the revised report and Action Plan. In terms of the assessment of DHR reports the QA Panel judges them as either adequate or inadequate. I am pleased to tell you that the revised report has been judged as adequate by the QA Panel.

The QA Panel would like to thank you for the clear efforts made to address the issues raised in the feedback letter from the QA Panel, particularly the efforts made to provide further details and analysis regarding the case.

There was one remaining issue that the Panel felt might benefit from more detail, and which you may wish to amend prior to publication of the revised report:

- Please include a target date column in your Action Plan against which the reader can measure the RAG ratings and to provide clarity on the progress that has been made.

Thank you for further clarification of your recommendation on page 13, that we highlight the 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. The Home Office notes the recommendation, and the reference to it in your Action Plan that includes a recommendation that the Home Office should consider introducing guidance on how small organisations and GP practices can conduct Independent Management Reviews in an independent and quality assured way.

I would like to reassure you that we are already working together with NHS England Regional leads who are working to identify mechanisms to support the management of NHS England participation in the DHR process across their regional boundaries. They will work together to consider and develop a standard approach. Guidance for managing DHRs will be considered as part of the review of the NHS Serious Incident Framework, and regional leads are liaising with colleagues in the Home Office to support the development of this guidance.

The Panel does not need to see another version of the report, but we would ask you to include our letter when you publish the report.

Thank you.

Yours sincerely,

Christian Papaleontiou, Chair of the Home Office Quality Assurance Panel

Head of the Interpersonal Violence, Violent Crime Unit