

DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

REPORT INTO THE DEATH OF ADULT MALE JOHN on 19 November 2011

Report produced by North Somerset People and Communities Board

25 November 2013

1. Introduction

This Executive Summary of a Domestic Homicide Review (DHR) provides a brief overview of the full DHR report regarding John, a resident of North Somerset prior to the point of his death on 19 November 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.

2. The Review Process

Circumstances leading to the Review

This review was commissioned by North Somerset People and Communities Board on 22 December 2011 following the unexpected death of John on 19 November 2011 and the arrest of his partner, Mary, who was charged with John's murder. Mary was subsequently found not guilty of murder or manslaughter.

Timescales and Methodology

This review originally began on 25 July 2012 following the conclusion of criminal proceedings. Independent Management Reviews (IMRs) were commissioned from Avon and Somerset Constabulary, John's and Mary's GPs, Avon and Wiltshire Partnership NHS Trust and Avon and Somerset Probation Trust. They were received by 10 December 2012.

Delays to the final report were caused by attempts to contact Mary and in order to allow contact with the family of John 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
Louise Branch CSP CSDAT North Somerset
DCI Phil Polet Avon and Somerset Constabulary
Fiona Birch Avon and Somerset Probation Trust
Helen Cottee Avon and Wiltshire Mental Health Partnership NHS Trust
Howard Potheary CSP CSDAT North Somerset
Richard Lyle NHS Bristol
Rhiannon Griffiths Safer Bristol

3. Confidentiality

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

4. Key Issues

4.1 Dual allegations of abuse were made and misuse of alcohol was a factor in the relationship. Mary had a long history of alcohol misuse and the couple liked drinking together. Although, it should be noted that John's family feel that his heavy drinking was historic and related to the death of his wife some years earlier.

4.2 The death was difficult to predict due to agencies' lack of up to date information on the couple's living circumstances and their use of alcohol and aggression. The information which was obtained and actions which could be taken were limited through a lack of co-operation from both John and Mary.

4.3 The dynamics within the abusive relationship could not be established but the use of a weapon at the time of the final incident tragically resulted in the death.

5. Lessons Learned, 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:

1. Raise awareness of domestic abuse with the public and workers particularly where it is linked to alcohol misuse
2. Improve risk assessments and information recording particularly where there are dual allegations of abuse and/or alcohol is a factor
3. Improve support for those who are in abusive relationships and who also misuse alcohol.

AGENCY	RECOMMENDATION	ACTION
Probation Trust	Improve A&S Probation risk assessment around DA	Training for all OM around Oasys improving practice and professional judgement is in place and is mandatory training for PO's and PSO's Probation Risk of Harm Audits

AGENCY	RECOMMENDATION	ACTION
		<p>Oasys QA – 4 cases for every OM Quality Assured each year</p>
CSP	<p>Ensure that agencies work to address both DA and alcohol misuse when they occur together by:</p> <ul style="list-style-type: none"> • Identifying and reducing risk in cases where there is both domestic abuse and alcohol misuse. • Recognising the complexity of the situation and the fact that a victim may not be able to address both DA and alcohol or substance misuse at the same time. 	<p>Encourage agencies to incorporate DA screening questions (using best practice from The Stella project) into their own risk assessment processes, starting with substance misuse, mental health and generic health support agencies. (where there is direct commissioning by the CSP a requirement for this to be added to the contract)</p> <p>Provide DA training focussed on alcohol misuse workers and health workers. Programme to include:</p> <ul style="list-style-type: none"> • Identifying DA • Risk assessment for DA esp. where there is alcohol/substance misuse • Responding to DA including -safety planning and referrals to MARAC and DA agencies • Working with perpetrators of DA
	<p>Ensure that, wherever possible, agencies use the RESPECT screening tool to identify primary perpetrator in cases of dual allegations</p>	<p>Add a requirement to use Respect screening tool to DA and substance misuse service contracts wherever possible.</p> <p>Provide multi-agency training and guidance on screening tool focussing on DA and substance misuse agencies, GPs and other health workers, probation, police</p>
	<p>Raise awareness of domestic abuse support for people using alcohol and other substances through provision of information to the public</p> <p>Raise awareness of domestic abuse support amongst licensees, other</p>	<p>Provide information* on recognising DA, support available and safety planning for display by substance misuse support agencies, pubs, bars and shops which sell alcohol to be aimed at the public and making it clear that both men and women can be victims.</p> <p>* posters, leaflets, stickers for toilet doors, branded products etc</p> <p>Provide information and advice on</p>

AGENCY	RECOMMENDATION	ACTION
	providers of alcohol and taxi firms	domestic abuse and sources of support to licensees and taxi firms through licensing department.
	Ensure that providers of alcohol support services are sensitive to issues around domestic abuse	Consult with survivors of domestic abuse and providers to determine what services are needed (eg, single sex groups?)
	Ensure that people renting accommodation in isolated areas, particularly static caravan sites, are provided with information on sources of support and local networks	Adapt travellers' leaflet for static home sites and provide to landlords
	Provide support for people who have fled domestic abuse to address their alcohol use	<p>Work with providers to incorporate addressing alcohol/substance misuse in their survivors' recovery programmes</p> <p>Work with drug and alcohol support providers to incorporate addressing relationship issues in their recovery work</p>
	Ensure that GPs have information on domestic abuse support services, including recovery programmes to provide to patients, particularly those with alcohol issues	<p>North Somerset: targeted information on Pattern Changing programme and the links to alcohol misuse to all GPs and health providers</p> <p>Ensuring that referral forms and information are up to date on the care pathways website accessed by GPs</p>
	Raise awareness of the wider definition of DA and that it can be experienced by other family members including parents	<p>Awareness campaigns on abuse of parents and family members to include:</p> <ul style="list-style-type: none"> • Press releases • Posters • Articles in council's own publications • Guidance to staff who have contact with people reporting DA
	Ensure that police and court based substance misuse workers always properly acknowledge record and act upon a DA disclosure from either a victim or perpetrator to ensure the individual is given information about support services.	<p>Training and information on DA services to arrest referral scheme workers</p> <p>Provision of information on DA support services in custody suites</p>
YOT	Ensure that alcohol related problems	Use the young people's substance

AGENCY	RECOMMENDATION	ACTION
	among young people are being sufficiently addressed.	misuse needs assessment to explore any gaps in services for young people with alcohol problems. This gap analysis should consider a full range of interventions, from prevention and awareness raising, to brief interventions, to outpatient treatment, up to inpatient treatment.
Public Health	Ensure that people who are abstaining from alcohol are provided with relapse prevention advice when most appropriate.	Write relapse prevention advice into commissioning contract with alcohol agencies
CCG	Ensure that medical records include information on previous domestic abuse and issues with alcohol and this is passed on to new areas.	
CCG	Encourage GPs to screen for alcohol issues so that they are referred to sources of support	Encourage GP practices to sign up to deliver alcohol Directed Enhanced Service

The full overview report of this DHR will be made available on the North Somerset Partnership website following Home Office approval.

www.northsomersetpartnership.co.uk