

**Domestic Homicide Review**

**EXECUTIVE SUMMARY**

**Report into the death of Margaret**

**Report produced by Peter Stride – Foundry Risk Management Consultancy**

**On behalf of North Somerset Community Safety Partnership**

**March 2018**

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## **1. THE REVIEW PROCESS**

The pseudonyms Margaret and David were used in this review in order to protect their identities.

The review was conducted in accordance with statutory guidance under s.9 (3) Domestic Violence, Crime and Victims Act (2004) and the expectation of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016.

There were no other reviews conducted contemporaneously that impacted upon this review.

The decision to hold a Domestic Homicide Review was made on 15 March 2017 and the initial review panel took place on 9 June 2017.

All agencies that may have dealt with Margaret or David prior to their deaths were asked to check their records and confirm whether they had any contact or not. Four agencies responded that they had had some contact and an Individual Management Review (IMR) and chronology was requested from each. Once received these were analysed.

Background information from the following was added in order to try to build up a picture of the context of the deaths: self-assessment surveys completed by panel members, the North Somerset Domestic Abuse Needs Assessment, 2016 and the North Somerset People and Communities Board Strategy consultation, 2017.

## **2. CONTRIBUTORS TO THE REVIEW**

**IMRs** were requested from the following agencies:

- Bristol Royal Infirmary
- Clinical Commissioning Group /Riverside Medical Practice
- North Somerset Community Partnership
- Weston Area Health Trust

Family members were invited to take part in the process but were adamant that they did not want to be involved in any way. Attempts were made to contact friends and neighbours but these were met with no response.

## **THE REVIEW PANEL MEMBERS**

The review panel consisted of:

- Peter Stride           Independent chair
- Mark Wolski           Vice chair
- Louise Branch        Domestic Abuse co-ordinator

- James Wright      Adults Safeguarding, NS Council
- Heather Stamp     Gemini Services manager
- Lorna Dollimore   Avon & Somerset Police
- Lucy Muchina      Clinical Commissioning Group.
- Dr Mike Jefferies   Riverside Medical Practice
- Danni Rowan       Avon and Wiltshire Partnership
- Jos Grimwood      North Somerset Community Partnership
- Carol Sawkins      Bristol Royal Infirmary

### **AUTHOR OF THE OVERVIEW REPORT**

The chair of the Review was Peter Stride. Peter has completed his Home Office approved training and received subsequent training by Advocacy After Fatal Domestic Abuse. Peter has over 30 years detective experience in the field of Domestic Abuse, Public Protection and Safeguarding in London. He has no connection with North Somerset

### **3. TERMS OF REFERENCE FOR THE REVIEW**

- To review the involvement of each individual agency, statutory and non-statutory, with “Margaret” and “David” during the relevant period of time:
- To summarise agency involvement between 19<sup>th</sup> January 2012 and 19<sup>th</sup> January 2017
- To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to identify and respond to disclosures of domestic abuse.
- To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result and as a consequence.
- To improve inter-agency working and better safeguard adults experiencing domestic abuse and not to seek to apportion blame to individuals or agencies.
- To commission a suitably experienced and independent person to:
  - chair the Domestic Homicide Review Panel;
  - co-ordinate the review process;
  - quality assure the approach and challenge agencies where necessary; and
  - Produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established terms of reference.
- To conduct the process as swiftly as possible, to comply with any disclosure requirements, panel deadlines and timely responses to queries.
- On completion present the full report to the Local Community Safety Partnership.
- Not to seek to apportion blame to individuals or agencies

#### **4. SUMMARY CHRONOLOGY**

David died in January 2017 as a result of a Road Traffic Collision after his vehicle collided with a tree. When police called at David's address in order to notify his next of kin of his death, the body of Margaret, his wife, was found in the bedroom.

Post mortem examinations determined that Margaret died "principally of a stab wound to the neck in the presence of blunt force injuries" and that David died due to "severe chest injuries typical of a road traffic collision".

The subsequent police investigation determined that David was responsible for the injuries which resulted in Margaret's death and that he had then driven his car at high speed into a tree.

At the time of their deaths Margaret was 70 and David 74 years of age. They lived in the Bristol area for many years where they raised their two children. Information from neighbours and friends collated by the police, as part of their investigation, indicates that they were a devoted couple with no financial problems or history of domestic abuse.

Both were relatively fit and healthy until December 2015 when Margaret was diagnosed as suffering from Chronic Obstructive Pulmonary Disease (COPD). She was later diagnosed with emphysema and used bottled oxygen to aid her breathing.

In November 2016 David had an abnormal liver function test and was advised to stop drinking alcohol for 6 weeks. On 16<sup>th</sup> January 2017 he disclosed to his doctor that he was suffering from insomnia, that he was stressed due to his wife's illness and the fact that household chores were now his responsibility. He was prescribed medication to assist with his insomnia.

Interviews with neighbours, carried out as part of the police investigation, provided information which indicated that David had been suffering from stress and anxiety in the time prior to the deaths.

#### **5. KEY ISSUES**

The key issues identified through analysis of collated information and panel discussions were:

- The impact of health and social cares responsibilities on emotional well being
- The impact of changing circumstances upon behaviour
- Social isolation
- Service provision
- Seeking assistance
- Risk identification and assessment
- Information exchange

#### **6. CONCLUSIONS**

David and Margaret appeared to live a peaceful life with little or no contact with community safety partnership agencies. The only issues raised were around the

health of Margaret and the impact this had upon David but it seems that he did not seek support from agencies for this.

Hindsight may indicate that there were opportunities for health care professionals to assess both parties and potentially introduce processes to mitigate any identified stress triggers. However, whether such an early intervention would have prevented this tragedy is unclear.

It appears that the death was neither preventable nor predictable. However, all circumstances such as these present opportunities to consider current methods, policies and working practices and the Chair of this review feels it is the role of the review panel to identify opportunities to improve services provided to residents, families and the wider community. The recommendations arising from this DHR are therefore aimed at enhancing current local and national provision. It is hoped that they will further reduce risks of domestic abuse and increase safety to those suffering in similar circumstances.

## **7. RECOMMENDATIONS**

- Reintroduce the use of the GP practice based IRIS Project to support hard to reach and isolated families and victims
- Embed the principles of Making Every Contact Count [MECC] approach across Health and Community Safety Partnership Professionals
- Raise the Profile of the Carers Act, Carers Stress and the Pathways to support across Professionals and Communities
- Health care professionals to review their risk and diagnosis frameworks to include assessment of cause, emotional, mental capacity and psychological impact
- Increase the engagement of volunteer's non-gain organisations to improve the opportunities for and social prescribing to support hard to reach groups and elderly patients
- Raise awareness of Domestic Abuse within the Community with particular reference to those over the age of 65
- Carry out a comprehensive Training Needs Analysis of CSP partners in respect of Domestic abuse across all agencies that have contact with communities
- Ensure bespoke service provision in respect of Domestic Abuse and the growing elderly population is available
- Enhance the use of the Carers Assessment by linking to the MECC project to identify early opportunities to recognise and manage risk within the elderly and hard to reach groups