Herefordshire

Community Safety Partnership

EXECUTIVE SUMMARY

DOMESTIC HOMICIDE REVIEW

Into the circumstances

of the death of a man aged 78 years

on 3rd November 2014

Case HDHR 04

Under Section 9 of the Domestic Violence Crime and Victims Act (2004)

Independent Author:
Malcolm Ross M.Sc.
January 2017

LIST OF ABBREVIATIONS

A&E - Accident and Emergency Department (Hospital)

ASC - Adult Social Care

CCG - Clinical Commissioning Group

CSP - Community Safety Partnership

DAU - Domestic Abuse Unit (Police)

DHR - Domestic Homicide Review

GP - General Practitioner

HCSP - Herefordshire Community Safety Partnership

HMC - Her Majesty's Coroner

IDVA - Independent Domestic Violence Advisor

MAPPA - Multi Agency Public Protection Arrangement

MARAC - Multi Agency Risk Assessment Conference

PPIG - Public Protection Investigation Unit

SIO - Senior Investigating Officer (Police)

Introduction

This Domestic Homicide Review (DHR) examines the circumstances surrounding the death of a 78 year old man on 3rd November 2014. The Deceased's partner was interviewed under caution about the death of the Deceased and a file presented to the Crown Prosecution Service (CPS). The CPS decided that there was insufficient evidence to suggest that the partner's actions caused the death of the Deceased and No Further Action was taken. The Home Office, however consider that the circumstances require a completed Domestic Homicide Review.

The report was presented to the Herefordshire Community Safety Partnership Board on 16th November 2015. On 16th November 2015, HM Coroner for Herefordshire returned an open conclusion at an inquest into the Deceased's death.

In view of the decision by Crown Prosecution Service, reference is made throughout this summary to 'the partner' rather than the 'alleged perpetrator'. The partner was seen by the report author and she expressed a wish that the Deceased should be referred to as the Deceased throughout the report.

Details of the legislation governing the Domestic Homicide Review process, the terms of reference, panel members and agencies that contributed to the review are contained in an appendix to this report.

For the purpose of this executive Summary of the Domestic Homicide Overview Report, the Deceased, partner, family members and other that were involved with the review process will be anonymised. A key is provided for ease of reading.

Deceased	Male, 78 years old,
Partner	Female, 70 years old, partner of deceased
N1	Neighbour
S1	Male, Son of Deceased by previous marriage
EW1	Ex-wife of Deceased, Mother of S1
EW2	Second Ex Wife of Deceased and mother of 2 children – male and female

Summary of Events

It is important to note at the beginning of this executive summary that after CPS considered there was insufficient evidence to prosecute the partner for any offence in connection with the death of the Deceased. West Mercia Police have taken no further action.

Before CPS had arrived at that decision the review was well underway and had already identified lessons to be learnt. The Home Office were contacted once CPS's decision was known and insisted that the full review process should continue irrespective that no criminal charges were to follow.

This Domestic Homicide Review concerns the death of the 78 year old man and his relationship with his 70 year old female partner. They had met many years ago when the Deceased worked in a senior position in the Civil Service in London. They lived together in London for some years. The partner still has a house and a flat in London. She rents the flat

and keeps the house for herself which she would use to return frequently to London for social reasons and also for respite periods when the domestic situation between her and the Deceased became untenable.

Some years ago the couple bought a cottage in a small village in Herefordshire near the Welsh border. Opposite the cottage were two public houses which became a relevant feature in their domestic relationship as time went by.

According to the partner the Deceased's life within the Civil Service was fuelled by alcohol. She described to the Overview Author how the Deceased would drink every lunch time and every evening, and that continued when they moved to Herefordshire. She stated he was an alcoholic. She also stated that she herself would drink on occasions in moderation.

It is known that the Deceased had numerous health problems including Asthma, urology and prostate problems, and was a regular attender at his GP.

Domestic upheavals between the two were a regular feature in their lives, mainly due to the Deceased's alcohol intake. It was not uncommon for customers at the public house to cross the road to the Deceased's house to help settle domestic arguments.

The attendance by Police after calls for assistance by the partner was also a fairly regular occurrence. As far back as December 2001, Police attended to a domestic incident where the partner was throwing furniture around the house, and during the argument with the Deceased, fell through a window cutting her wrists. This incident predated Public Protection Unit Domestic Abuse booklets.

In December 2012 Police responded to a call alleging the Deceased had been slapped by a neighbour over an argument about a dog and 7 days later Officers attended again following a call from the partner that the Deceased was drunk and they were arguing. A Domestic Abuse Booklet was submitted by the Officers who referred the matter to an Independent Domestic Violence Adviser (IDVA). Officers from the Domestic Abuse Unit attempted to contact the partner but she failed to return the calls.

In May 2013, the Deceased called the Police stating that the partner had threatened him with a kitchen knife. Officers dealt with the incident by removing the partner who stated she wanted to go back to London and to seek legal advice. Again the necessary booklet was submitted.

During September and December 2013, the Deceased was seen at his GP's surgery on 3 occasions alleging that he had fallen and injured himself.

In April 2014, the Deceased was diagnosed as having Macrocytosis which indicates larger red blood cells than normal and may be signs of an underlying medical problem. He was told that it was thought he may be drinking too much.

In July 2014, he complained to his GP that he had twisted his back.

On 20th October 2014, a neighbour called at the Deceased's house. He was on his own as the partner had returned to her house in London to attend several plays and concerts. The Deceased was on the floor in pain and reported that his partner had pushed him over 11 days before and injured his back. He had laid on the floor the previous night in an attempt to relieve the pain but found he couldn't get up. (The partner told the report author that before the she left for London, she and the Deceased went to the theatre and she described him as walking in the normal way.)

An ambulance attended and took him to the local hospital where he was detained. A Police Officer attended and the Deceased repeated his allegation about being pushed over by the partner.

The Officer made arrangements to see the Deceased once he was discharged from hospital under the impression that his injuries were of a minor nature.

The partner was informed that the Deceased had been admitted to hospital and she returned to Herefordshire. This incident was recorded by the Police as a common assault based on the Deceased's verbal account of being pushed over some 11 days previously. A Domestic Abuse Form was completed and the risk assessed as 'low risk'. Once the form had been received by the Domestic Abuse Unit, the risk was upgraded to medium and for the Deceased to be seen again.

The same Officer visited the home address 11 days later to be told that the Deceased was still in hospital and his condition had deteriorated. That same day the Officer saw the partner and interviewed her under caution. She explained that he had been drunk on the day of the incident and he was threatening her and as he came towards her she pushed him in self-defence. He fell to the floor. She helped him to his feet and put him in an armchair. She gave him a whiskey and she went to bed in her own bedroom and she was aware of the Deceased coming to bed 30 minutes later.

Adult Social Care were made aware by the Police and expressed the view that it was essential that the Deceased be seen prior to him being released from hospital in order that any risk posed by the partner could be assessed before the Deceased was discharged.

Adult Social Care attempted to contact the Officer but because of shift pattern it was 4 days before the Officer responded to an email from Adult Social Care in which the Officer stated that he thought there were no safe guarding risks or concerns for the Deceased.

The Deceased's condition deteriorated and he never recovered sufficiently to be interviewed. He died on 3rd November 2014, the cause of death being recorded as Multi Organ Failure, Pseudomembramous Colitis complicating antibiotic treatment for hospital acquired Pneumonia in a patient with spinal and rib fractures. It is also recorded that Cirrhosis (alcohol), Osteoporosis, Chronic Obstructive Pulmonary Disease and Hypertension also contributed to his death.

A Forensic post mortem was conducted by a Home Office Pathologist and after extensive examination that the Pathologist concluded

> "the [Deceased's] injuries and the attendant immobility requiring hospitalisation have more than minimally contributed to his subsequent death, in conjunction with his underlying natural disease I am unable to say exactly how the injuries were caused."

During the subsequent Police investigation, information came to light that it was alleged that whilst the Deceased was detained in hospital, the partner was found pouring liquid into the mouth of the Deceased despite there being a nil by mouth sign at the head of the bed. The Wye Valley NHTS Trust IMR does not record any concerns over the behaviour of the partner whilst she was at the Deceased's bedside. About this the partner stated to the report author that she had merely been wiping her partner's mouth with a small wet sponge on a stick and she neither removed pillows from under his head or tried to pour water into his mouth.

Additional information was received from a family friend who reported that the partner had confided in her that she had been attempting to mix substances with her partner's whiskey with intent to harm him. Again, the partner refutes this allegation and stated to the report author

that she had tried to mix paracetamol with a drop of whiskey as pain relief but her partner had not taken the mixture and she had thrown it away the following morning as it had gone cloudy.

Both of these allegations were denied and during an interview under caution with Detective Officers, the partner repeated the events as described in her earlier interview under caution.

The basis of the decision by CPS was that there was insufficient medical link between the Deceased's fall and his death and the Deceased may have fallen again in the 10 day period that he was on his own after the initial incident with the partner.

Analysis

There is no doubt that the partner and the Deceased lived a turbulent life but for some reason stuck together even though alcohol was constantly present.

There is little evidence that the Deceased received any advice or support in relation to his alcohol problem and it is also the case that on numerous occasions the Police were called mainly by the partner (but less often by the Deceased) in order just to settle arguments between them.

In the main the Police response conformed to guidance and made the suitable referrals to Adult Social Care and the IDVA system (although Women's Aid has no record of any referral). On each occasion there was no formal complaint made against the other partner, whichever that may have been at the time, so no criminal action was taken.

The Police IMR identifies a lack of attention in the paperwork trail regarding the Risk Assessment which was amended by the Domestic Abuse Unit and makes recommendations within the IMR which adequately covers those issues. So too, the area around the Deceased not being seen in hospital for some 11 days during which time his medical condition deteriorated to such an extent that he was not seen by the Police at all before he died.

The IMR for Wye Valley NHS Trust that treated the Deceased once he had been admitted into hospital, points out that staff at the hospital were diligent in their record keeping, medical, nursing and therapy interventions with the Deceased whilst he was in their care, as well as good evidence of multi-agency discussions regarding the future plans once he was discharged, which unfortunately never came to fruition.

There is nothing to suggest that the Deceased was referred for or sought help for his alcohol problems. The partner told the Overview Report author that she herself sought assistance from Alcoholics Anonymous (AA) for advice as to what she could do to help the Deceased regarding his drinking problem but was sure that he had not been given advice irrespective that the Deceased's GP was aware of the extent to which the Deceased was drinking.

The Overview Author considers that the issues raised for agencies during the review process are more than adequately dealt with in the respective IMR recommendations and action plans attached to this report.

Conclusions

There is no doubt that a more assertive response by the Police to the calls from the partner could have been made. There is little to suggest that there is consideration given to a victimless prosecution but on every occasion other than the last event, neither the Deceased nor the partner wished to make a complaint which probably influenced Police action.

There were opportunities for support to be offered to either of the couple but history indicates that the Deceased in particular was highly unlikely to have accepted support. He was also highly unlikely to change his lifestyle or alcohol intake which was the route cause for the domestic upheavals.

Given the circumstances and the history of this couple, the death of the Deceased could not have been predicted or prevented, but further domestic incidents were more than likely to have occurred. Whilst the history of domestic violence was known about the extent of the 'violence' did not indicate any escalation on behalf of either partner and there has not been a causal link established between her pushing the Deceased and his death.

Herefordshire Community Safety Partnership

Domestic Homicide Review Case No. 4

ACTION PLAN

Adult Social Care IMR Recommendations

Recommendation	Action Required by Agency	Implementation Lead	Target date for Completion	Summary of Action Taken & Date
Improved contact details	ASC to identify and record NOK and family contact details on front screen of fwi. To include name, address, phone numbers.	Safeguarding operational lead	10 /9/15	Inform team leads at team leads meeting and take to practitioner forum on 10/9/15
Improved communication with self-funders.	To ensure that advice , information and assessments are offered to self-funders	Safeguarding operational lead	31/7/15	This action is now evident in practice and is a requirement of the Care Act 2014.
Reliable recording of information	Ensure that accurate case records are in place which evidences work undertaken and defensible decision making.	Safeguarding operational lead	10/9/15	Direct practitioners to Policy and Procedures document on record keeping. March 2015 Take learning from DHRs to the Practice forums.

Herefordshire Community Safety Partnership

Domestic Homicide Review Case No. 4

ACTION PLAN

West Mercia Police IMR Recommendations

Recommendation	Action Required by Agency	Implementation Lead	Target date for Completion	Summary of Action Taken & Date
Risk assessments conducted by initial attending Police officers must be promptly submitted to ensure appropriate support and referrals to other agencies can be made.	Removal of delays in risk assessment & referral process.	PVP Superintendent Eccleston	June 2015	Action had already been taken to improve this situation prior to the DHR as it was a consistent problem across the Policing area. Paper-based risk assessments no longer exist and DASH is electronically recorded prior to the attending officer going off shift. This assessment is then immediately available for staff to see & is electronically forwarded to the MASH where it is assessed and referred either the same, or next working day.

Recording of risk assessment decisions must be clearly documented on Police systems to explain rationale, especially where risk levels are amended.	Clear documentation of risk assessment and reasoning for re-categorisation	PVP Supt Eccleston – allocated to HAU Supervisor – Worcester - Lisa Ignoscia	Dec 2015	Current working practice within HAU is that decision making re risk is recorded clearly. This is monitored by supervisors & staff involved in decision making in 2013 now work in HAU, & are robust in adherence to this practice. A reminder has been sent by the HAU supervisor reminding all staff of the importance of this.
The actions taken by the attending Constable, with supervisory sign off to be addressed, specifically regarding the submission of a Standard risk assessment in the circumstances outlined, & the filing of the Common Assault investigation despite a significant deterioration in the Deceased's condition.	Advice to be given to individual officers relating to their recording and decision making. The need to take account of other information / history when conducting risk assessments is a recurring feature of reviews & subject of wider training / input to staff.	DCI Paul Judge – Local Investigation – Herefordshire.	December 2015	Completed

NHS
Herefordshire
Clinical Commissioning Group

Herefordshire CCG

Domestic Homicide Action Plan

In Respect of 3 Domestic Homicides

Recommendation	DHR	Action	Lead	Timescales	Evidence
Map of Medicine to include the care pathway for domestic abuse	HDHR 04	Post HSCB/HSAB/CSP sign off of domestic abuse care pathway upload the pathway onto Map of Medicine	SC	March 2016	Completed
The CCG to include a link to the document managing pain in	HDHR 04	SB to include link in GP newsletter	SB	November 2015	Info included in pharmacy Completed

dementia in their next GP newsletter					newsletter to GP practices
The CCG should work with GP practices to develop a universal care plan format which includes information regarding the social aspects of a person's care	HDHR 04	Review current care plan format, include social element, trial across several practices, review and amend as necessary. Distribute finalised version across GP practices	LR	March 2016	Completed
The surgery should review their processes for documenting alcohol consumption when concerns arise about alcohol use	HDHR 04	PM to work with GPs to agree processes. Embed process across all disciplines working in surgery	Practice manager	November 2015	Completed
The CCG should utilise the Map of Medicine care pathways approach to support GPs in their work re alcohol abuse and the links between alcohol misuse and domestic abuse	HDHR 04	Review current Map of Medicine, amend as necessary, agree with substance misuse services and GP practices. Publish agreed Map	SC	January 2016	Completed
The Map of Medicine care pathway for falls should be reviewed to include alcohol misuse	HDHR 04	Review current Map and amend as necessary	SC	January 2016	Completed

Appendix No 1

Terms of Reference

DOMESTIC HOMICIDE REVIEW

into the circumstances

of the death of a man aged 78 years

on 3rd November 2014

Case HDRH 04

The Domestic Violence, Crimes and Victims Act 2004, establishes at Section 9(3), a statutory basis for a Domestic Homicide Review, which was implemented with due guidance[1] on 13th April 2011. Under this section, a domestic homicide review means 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 he was related or with whom he was or had been in an intimate personal relationship, or*
> *(b) a member of the same house hold as himself, held with a view to identifying the lessons to be learnt from the death"*

In March 2013, the Government introduced a new definition of domestic violence and abuse[2], that states that domestic violence and abuse is:

> *"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:*
> - *psychological*
> - *physical*
> - *sexual*
> - *financial*
> - *emotional*

In accordance with the statutory guidance, a DHR Panel was established to oversee the process of the review. The members of the panel consisted of senior professionals from:

[1] Multi-Agency Statutory Guidance For The Conduct of Domestic Homicide Reviews - Home Office 2011 *www.homeoffice.gov.uk/publications/crime/DHR-guidance*
[2] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised August 2013 Home Office

- Learning and Development Officer, HSCB/HSAB/HCSP
- Principal Social Worker, Adult Social Care Herefordshire Council
- Head of Safeguarding – CCG Quality
- Lead Nurse Adult Safeguarding, Wye Valley NHS Trust
- Deputy Director of Nursing – 2gether, NHS Foundation Trust
- Assistant Chief Officer, National Probation Service
- Chief Executive, West Mercia Women's Aid
- West Mercia Police
- Safeguarding Lead, Adults Wellbeing, Herefordshire Council
- Observing members from West Mercia Women's Aid and Hereford CCG.

The CSP appointed an independent author and chair to be responsible for writing the report and chairing the panel meetings.

None of the panel members or the independent author had direct involvement in the case, nor had any line management responsibility for any of those involved.

It was decided that the review should focus on the period 1st January 2010 to the date of the deceased's death on 3rd November 2014.

The following agencies were requested to prepare chronologies of their involvement with the deceased and her family, and to prepare individual management reviews and produce reports:

- West Mercia Police
- Health – Wye Valley Trust, GP's, Herefordshire CCG and 2gether NHS Trust
- Adult Social Care Herefordshire County Council
- West Mercia's Women's Aid

and a report from:

- Kemble Care

Terms of Reference

The Terms of Reference for this DHR are divided into two categories i.e.:

- the generic questions that must be clearly addressed in all IMRs; and
- specific questions which need only be answered by the agency to which they are directed.

The generic questions are as follows:

1. Were practitioners sensitive to the needs of the deceased and the partner, knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a deceased or partner?
2. Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?
3. Did the agency have policies and procedures for risk assessment and risk management for domestic abuse deceased or partners (DASH) and were those assessments correctly used in the case of this deceased /partner?
4. Did the agency have policies and procedures in place for dealing with concerns about domestic abuse?

5. Were these assessments tools, procedures and policies professionally accepted as being effective? Was the deceased subject to a MARAC?
6. Did the agency comply with domestic abuse protocols agreed with other agencies, including any information sharing protocols?
7. What were the key points or opportunities for assessment and decision making in this case?
8. Do assessments and decisions appear to have been reached in an informed and professional way?
9. Did actions or risk management plans fit with the assessment and the decisions made?
10. Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?
11. When, and in what way, were the deceased's wishes and feelings ascertained and considered?
12. Is it reasonable to assume that the wishes of the deceased should have been known?
13. Was the deceased informed of options/choices to make informed decisions?
14. Were they signposted to other agencies?
15. Was anything known about the partner? For example, were they being managed under MAPPA?
16. Had the deceased disclosed to anyone and if so, was the response appropriate?
17. Was this information recorded and shared, where appropriate?
18. Were procedures sensitive to the ethnic, cultural, linguistic and religious identities of the deceased, the partner and their families?
19. Was consideration for vulnerability and disability necessary?
20. Were Senior Managers or agencies and professionals involved at the appropriate points?
21. Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?
22. Are there ways of working effectively that could be passed on to other organisations or individuals?
23. Are there lessons to be learnt from this case relating to the way in which this agency works to safeguard the deceased and promote their welfare, or the way it identifies, assesses and manages the risks posed by partner? Where could practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?
24. How accessible were the services for the deceased and the partner?
25. To what degree could the homicide have been accurately predicted and prevented?

In addition to the above, some agencies will asked to respond specifically to individual questions once they are identified following the submission of IMR's