Executive Summary

of a

Domestic Homicide Review
DHR W 03

into the death of a 56 year old woman
'Trish' in November 2017

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Independent Chair and Author

Amended February 2022

List of Abbreviations

ATPL	Air Transport Pilot's Licence
CAA	Civil Aviation Authority
CPL	Commercial Pilot's Licence
CBT	Cognitive Behaviour Therapy
CWPT	Coventry and Warwickshire Partnership Trust
CCG	Clinical Commissioning Group
DACS	Domestic Abuse Counselling Service (includes Insight, Counselling & Coaching Support Services ICCSS)a free charity grant funded Counselling Service.
DASH	Domestic Abuse, Stalking and Harassment Risk Assessment form
DHR	Domestic Homicide Review
DVAS	Domestic Violence Abuse Service
EAP	Employees Assistance Programme
GP	General Practitioner
HR	Human Resources
IAPT	Improving Access to Psychological Therapy
IDVA	Independent Domestic Violence Advisor
IRIS	Identification and Referral to Improve Safety
IMR	Individual Management Review
MARAC	Multi-agency Risk Assessment Conference
MAPPA	Multi-agency Public Protection Arrangements
MIND	Mental Health Charity
NICE	National Institute for Clinical Excellence
NHS	National Health Service
PPL	Private Pilot's Licence
RCGP	Royal College of General Practitioners
SIO	Senior Investigating Officer
SWFT	South Warwickshire Foundation Trust
UHCW	University Hospital of Coventry and Warwickshire
SWCSP	South Warwickshire Community Safety Partnership
SWCSPB	South Warwickshire Community Safety Partnership Board

Introduction and Background

The members of this review panel offer their sincere condolences to the family of 'Trish' for the sad loss in such tragic circumstances.

Trish's Mother and son insist that her daughter is referred to throughout the report by the pseudonym 'Trish'.

Due to the Perpetrator not engaging in the process, he will be known throughout the report as 'the Perpetrator'.

Introduction

This Review concerns the death of Trish who was aged 56 at the time of her death in November 2017. She was married to the Perpetrator, a Pilot Captain working for a travel airline. Several months before her death, the couple had parted and the Perpetrator lived elsewhere. Trish stayed in the family home. It was only after the separation that Trish confided in a couple of her closest friends that there had been domestic abuse from her husband. There was animosity regarding the sale of the house that had led to advice being sought by Trish from a solicitor.

One evening in November 2017, the Perpetrator visited a local public house and spoke to an acquaintance saying that he had killed Trish in her home. Before the acquaintance could call the police, the Perpetrator had left the public house in his car. He had also telephoned a friend of his in the south of England and admitted the murder. That friend was in the middle of trying to contact the local police in Warwickshire.

Warwickshire Police circulated the details of the Perpetrators car and he was arrested a few miles away. Officers went to the home address of Trish and found her deceased.

Warwickshire Police arrested and charged the Perpetrator who was subsequently convicted at the Crown Court for the murder of his wife.

It appears from evidence gathered for the criminal prosecution of the Perpetrator and from the information gathered during this review process that for a considerable time Trish suffered significant controlling and coercive behaviour from her husband and on occasions, physical, emotional and financial abuse.

In accordance with Home Office Guidance[1] a Domestic Homicide Review has been commissioned.

The Terms of Reference and other administrative issues are contained in an appendix to this report.

[1] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office 2016

Subjects of the Review

The following genogram identifies the family members, friends and colleagues in this case, as represented by the following key:

Victim	Trish
Perpetrator	Husband of Trish
Son	Son of Trish
Mother	Mother of Trish
Ex W	Ex-wife of Perpetrator
F 1 – F5	Friends and colleagues of Trish
C1	Colleague of Perpetrator

Summary of Recommendations

Overview Report Recommendations

Recommendation No1.

DACS review their referral process to include:

1a) Ensuring that referral forms are examined in detail and the appropriate risk assessment is made on the information available.
1b) In the case of a delay in DACS responding to a referral. The referring agency is to be informed by DACS of the delay with a special request that the referring agency advises the victim of the delay.

Recommendation No. 2

All agencies making referrals to DACS for victims of domestic abuse ensure that referral forms are followed up and enquiries made of DACS as to;

a) the action DACS will be taking,
b) how any time delay and back log will affect the victim and
c) whether the referral is to be progressed by DACS or not, thus enabling alternative support to be arranged by the referring agency.

Recommendation No 3.

Warwickshire CCG's to ensure that all GP surgeries are compliant with the RCGP guidance issued in 2011, regarding adopting a more robust proactive approach towards domestic abuse within all GP surgeries.

Recommendation No 4.

Warwickshire County Council to embark on a publicity campaign advertising by campaigns, posters, seminars etc., the opportunities for victims of domestic abuse, their friends and family members in Warwickshire to locate help support and advice about domestic abuse support.

Recommendation No 5.

South Warwickshire Community Safety Partnership to liaise with the Solicitor's Regulation Authority and the Law Society to raise awareness of potential missed opportunities and to encourage the training of Solicitors acting in the divorce arena of law so as to enable victims of domestic abuse to receive appropriate legal advice and to be signposted to specialist domestic abuse support services.

Recommendation No 6.

Refuge to maintain contact with National Association of Estate Agents to ensure continued support from NAEA in the distribution of domestic abuse literature to victims of domestic abuse as and when necessary.

Individual Management Report Recommendations

Warwickshire CCG IMR Recommendations

- Focused and targeted IRIS awareness improvement in General practice by the Advocate Educators / Clinical lead within Warwickshire. This will be an ongoing piece of work over the forthcoming year.

- Re-circulation of the Duluth power and control wheel and RCGP Domestic abuse toolkit to all Warwickshire practices. This will be completed by 31.7.18.

- Review of the training and education of Registrars in relation to Domestic abuse and IRIS. Discussions to be held by the 31.7.18

- Warwickshire Clinical Commissioning Group Safeguarding Leads will review the GP self-assessment safeguarding tool to include assurance on domestic abuse interventions. To be completed by 30.9.18

- Warwickshire Clinical Commissioning Group Safeguarding Leads, in partnership with the Named GP, will deliver a tailored safeguarding programme to all practice safeguarding leads to ensure they can deliver enhanced knowledge on domestic abuse. Dates to be disseminated to safeguarding practice leads by 31.7.18

- Dissemination to all Primary care teams of the DASH risk assessment tool. To be completed by 31.7.18

Coventry and Warwickshire Partnership Trust IMR Recommendations

- In order to ensure that CWPT staff are able to recognise the importance of using the DASH to understand the history of abusive behaviours in the context of current risk, a formal agency recommendation is that a greater emphasis is given to this during CWPT Level 2 Safeguarding Training and CWPT Level 3 Domestic Abuse training.

- Staff to be reminded via CWPT training and 'all user' message facility that it should be made clear to patients at the beginning of any assessment that in the interests of continuity of care information will be shared with the client's GP. Patients can then make an informed decision about the information they share with the assessing clinician.

South Warwickshire Foundation Trust IMR Recommendations

- South Warwickshire Foundation Trust are compliant with NICE Guidelines - Domestic violence and abuse Quality standard [QS116] Published date: February 2016 and will continue to report and monitor incidents relating to this area and to take learning from incidents.

- Safeguarding Adults training has been updated to provide increased information for staff regarding domestic abuse, how to recognise and how to engage with routine enquiry.

Summary of events.

Introduction.

It is with the wishes of the son and mother of the deceased that she is referred to as 'Trish' throughout this review process. The Perpetrator has refused to engage with the review and/or the author of this report and therefore a suitable pseudonym cannot be attributed to him. He will therefore be known as 'Perpetrator'[2]. The Overview Author is not minded to attribute a pseudonym to someone who is not engaging at the risk of causing offence to the Perpetrator or another person.

Trish was 56 years of age when she was murdered by her husband, the Perpetrator in her home one evening in November 2017. The Perpetrator was arrested and charged with her murder. He subsequently appeared before the Crown Court and pleaded 'Not Guilty' to her murder. After a trial, he was convicted and sentenced to life imprisonment with a recommendation from the Trial Judge that he serves 17 years before being considered for parole.

Trish

Trish was the second child born of her parents. Her older brother died from illness a few months before Trish's murder. She was married some years ago to her first husband. They had one child, who is called the son in this report. He is now an adult. That marriage came to an end by mutual agreement between Trish and her then husband. She went on to have other relationships, one for some time but it transpires that that partner was of a controlling nature and they eventually separated.

Trish had worked in the administration departments of a Local Authority and also of a local industrial business, but for some years before her death she qualified and had her own business as a beautician and specialised in nail therapy. This was located in the town where she lived. Her business is described by her son and her friends as being a thriving business, with many regular customers and also passing trade. She had a small, relatively new car that she was very fond of. Her son describes Trish as a very talented woman who regularly made attractive ornaments for old and antique materials, a process called 'upcycling'

The Perpetrator

The Perpetrator had also been married before and had two children with his first wife. Although he has declined to engage with this review process, information has been gained by talking to his ex-wife and his former employer. He was married to his first wife when he and she were both in their early 20's. The ex-wife described him as being a man of all trades and at the age of 26 years he qualified to be a pilot. He worked for several airline companies before settling with a large commercial airline that specialises in holiday packages.

His ex-wife described their marriage as ideal with the Perpetrator providing all that he could for the family. He became a Captain around 1998/2000 and she described how, with extra money in his salary, he would flaunt his money and boast about his wealth. He started to drink alcohol and he changed. She discovered that he was having an affair and the marriage ended.

[2] As per Home Office DHR Training Course Bristol April 2014.

Trish and the Perpetrator

Trish was introduced to the Perpetrator by a mutual friend and they became attracted to each other and a relationship began. During the process of this review and because there were so few agencies involved, the Report Author has liaised with numerous of Trish's friends to ensure that the voice of the victim is heard throughout this report.

Some of Trish's friends took a liking towards the Perpetrator, but others dislike him they had concerns that Trish had fallen 'head over heels in love' with the Perpetrator after only a short period of time. Not long after they met Trish announced that the Perpetrator was moving in with her. He had sold his own house and a short time later, they announced that they were engaged to be married.

Once the Perpetrator moved into Trish's house, friends saw a difference in both the Perpetrator and Trish. Trish became much more withdrawn and insular especially towards particular friends who she had known for years. The Perpetrator became controlling and insisted that Trish did not see some of her friends that he took a dislike to.

The Perpetrator fell out with a neighbour over some land issues and mentioned to Trish that 'he could kill him sometimes'. He had his own way regarding furniture in Trish's house and changed some to suit himself. He changed the floor material and changed Trish's small car buying her an older, larger car that was wholly unsuitable for her to drive.

Customers of Trish describe how when they went to see her to have their nails treated the Perpetrator would conceal himself in an adjoining room, a toilet, and listen to the conversation between Trish and the customers. He is also described as making frequent interruptions on the basis of request for tea, sandwiches or to announce that he was going to the shops. On his return he would announce that he was back. Customers found his behaviour strange and even 'creepy'. If the Perpetrator was in bed after a night flight, Trish would be on 'tender hooks' in case any noise woke him.

It was clear to some of her friends that the Perpetrator was controlling her.

Eventually Trish and the Perpetrator were married but not long after that Trish was taken to hospital by a female friend with an injury to her face, caused, she said, by her tripping and falling onto a coffee table. Trish admitted years later (once the Perpetrator had left her), that the injury had been caused by the Perpetrator and that not long before the wedding he had hit her in temper. Some of her friends describe how they would see bruises on her arms that were clearly finger garb marks but when asked about them Trish would say that she had fallen in the potting shed. One friend asked her outright if she had been hit and she denied it, saying that everything was fine between her and the Perpetrator.

Not long after the marriage the Perpetrator decided that they would move house to a much larger house in a very small hamlet quite a distance from Trish's house and business. The Perpetrator arranged the mortgage and they moved. The move cost Trish about 50% of her business as only her regular customers, many of whom had now become very good friends, would travel to her new home. The Perpetrator stated his intention to build a garage which he would turn into a 'pub' and it would have a room above where Trish could carry on her business. That never materialised, but he did insist that she stopped using acrylic in her nail treatment because he was offended by the smell. This she did with an effect of again reducing her income

considerably because the use of acrylic is essential in some of her nail treatment processes.

Trish discovered that the mortgage the Perpetrator took out for the new house was in his name only and he offered an excuse why that had happened. It is of interest to note that exactly the same happened with the mortgage for a house with his first wife and again he had an excuse as to why it had happened that way.

Trish discovered that the Perpetrator was having an affair (as he did with his first wife) and the marriage fell apart resulting in the Perpetrator moving out of the house, but taking his dog with him. However, he gave the dog to a neighbour to look after without telling Trish and she thinking that he had the dog with him, bumped into the neighbour walking the dog not far from her house causing her considerable embarrassment. Trish and the Perpetrator separated not long afterwards. She stayed in the matrimonial home and he went to live elsewhere.

Medical records from Trish's GP indicate that she had numerous appointments complaining of being depressed and anxious during the summer of 2017. The GP referred Trish to IAPT who contacted Trish and completed a questionnaire over the telephone. She explained of her grief of her brother's sudden death at the beginning of 2017 and the break-up of her marriage due to the Perpetrator's behaviour, drinking and violence towards her. She explained that since the Perpetrator had moved out she had been concerned and worried that he was returning to the house when she was not there. She would return and find ornaments and other objects moved from where she had put them and on occasions found the lawn had been cut. It was clear that the Perpetrator had been in the house and wanted to make it known to her. This was an ongoing fear for Trish so much so that when she was alone in the house she would lock the door and keep the key half turned in the lock. She had also put door jams under the external doors. This was explained in the IAPT questionnaire.

On 13th October 2017, IAPT emailed the referral form to DACS. DACS assessment of the form was that the circumstances warranted a low risk and DACS are in the unfortunate position of only being able to deal with high risk cases. There was a twenty week waiting list for the very few DACS workers to see Trish. There was no communication between DACS and IAPT to inform IAPT of the twenty week delay which may have given IAPT opportunity to consider alternative referrals. Trish had no contact with DACS. According to the DACS Manager, at this time DACS were only working with high risk referrals and some low risk referrals that were being dealt with by volunteers. However this had not been communicated to referring agencies until the following March when the funding process changed. More about DACS is included later in this report. Later in October 2017, Trish again visited her GP with anxiety and depression and she reported that she was waiting for domestic abuse counselling from DACS which of course she was not likely to receive due to her being assessed as low risk.

Following the Perpetrator moving from the family home Trish made an appointment to see a Solicitor from a company that specialise in divorce proceedings. It is known from a number of Trish's friends that have been seen by the DHR Author that Trish disclosed to the Solicitor detailed circumstances of her abusive life with the Perpetrator, which would be expected when seeking advice in divorce proceedings. In her statement to the criminal investigation the Solicitor said Trish had disclosed three incidents of domestic violence in 2014, 2016 and 2017. It is believed that the Solicitor advised Trish that she should not change the locks on the door of the house and friends of Trish have said that Trish took away from the appointment with the Solicitor, that if she reported the Perpetrator to the Police he would lose his job which

would then adversely affect Trish in the divorce proceedings. The Solicitor offered Trish mediation which Trish immediately refused for fear of coming face to face with the Perpetrator. The Solicitor did not signpost Trish to any domestic abuse services that may have been able to assist her and provide her with some support. The Solicitor did however draft a letter of concern to the Perpetrator about his behaviour.

With regards to the actions of the Solicitor the DHR panel considered that civil proceedings may have gone some way to minimise the risk that the Perpetrator posed to Trish even if matters had not been reported to the Police. From the file note of the appointment with Trish (which was exhibited to the statement provided in criminal proceedings) the Solicitor documented that she had discussed with Trish the option to pursue Civil proceedings to obtain an Injunction against the Perpetrator and possibly an Occupation Order. However, the Solicitor documented that the problem with such remedies were the cost. There was no exploration of Trish pursuing Civil proceedings herself and Trish was informed that she would not qualify for Legal Aid because there were no Injunction proceedings and no Police proceedings either. She had been subjected to domestic abuse by him. Trish's friend said that the Solicitor advised Trish to try and obtain as much money as she could out of the sale of the house despite the fact that the Perpetrator was anxious for a quick sale at a reduced cost.

The Panel considers that the Solicitor's steer on the matters could be regarded as somewhat dismissive and there seemed to be a discouragement from exploring formal proceedings against the Perpetrator. With that in mind the DHR panel make a recommendation that the Community Safety Partnership should refer its concerns in this case to the Solicitors Regulation Authority for a consideration of a review and any necessary action. The Overview Author has written to the Solicitor on two occasions requesting that she engages with the DHR process. There has been no reply or acknowledgement of the letters from the Solicitor.

The Perpetrator visited Trish one evening in November 2017 to try and negotiate a quick sale of the house for a reduced amount. The Perpetrator was insisting that the house be sold quickly as he was desperate for money. It appears an argument took place during which the Perpetrator brutally attacked Trish in the kitchen where she died of her injuries. The Perpetrator left the scene and eventually went to a local public house where he admitted what he had done to an acquaintance who was a civilian member of Warwickshire Police. He raised the alarm but the Perpetrator had left the public house before the Police arrived. The Perpetrator had already called a close friend of his in the south of England and told him what he had done. This person had contacted West Midlands Police who were in the process of notifying Warwickshire Police. The Perpetrator was apprehended a short time later near Rugby, arrested and ultimately charged with Trish's murder.

The Perpetrator pleaded not guilty to murder at the Crown Court in 2018 but following a trial he was convicted and sentenced to life imprisonment with a suggested period of 17 years before considered for parole.

Following the commencement of the DHR the Overview Author spoke to the Perpetrator's first wife who described her life with the Perpetrator as being aggressive, but not to the point of physical violence. He arranged the mortgage for their house in his own name and he spent a vast amount of money on motorbikes and other unnecessary items. She described how he would earn a good salary as a Captain but had a drink problem and would like to be seen as she described 'flashing the cash'. He was very extravagant with his money and she eventually discovered he was having an affair and they divorced. She described how one airline company he

worked for knew of his alcohol problem and referred him for counselling, but he never took that up. He did however, continue to fly.

With that in mind the Overview Author has made considerable enquiries with the airline companies the Perpetrator had worked for and has had considerable assistance from the company that were employing him at the time of the death of Trish. It appears that he worked for six airlines in all dating back to the 1990's and some of those airlines have now gone out of business. There is nothing recorded with the last company he worked for to indicate that they were aware of an alcohol problem but he was referred to occupational health due to episodes of 'flight fatigue', meaning he felt unwell during a flight which he alleged was due to lack of sleep due to his matrimonial problems. He took a three week leave period. In July 2017, he disclosed he was unable to cope with work and he had left Trish. He was advised to see his GP and his company referred him to their Employee Assistance Programme who referred him to a counsellor and he was eventually seen by an Aeromedical Examiner. The Aeromedical Examiner has been spoken to by the Overview Author. The Author prepared a series of five questions which the Aeromedical Examiner has answered. Both questions and answers are set out in the Overview Report.

Trish was a very popular person and had a wide circle of loyal friends. Because this review does not concern a large number of agencies the Overview Author, in seeking the voice of Trish has over a period of several months visited and spoken to eleven of Trish's closest friends. Details of the conversations with all eleven friends are set out in the Overview Report but for the purpose of the Executive Summary their comments herein are conjoined and summarised.

Trish's friends describe her as a beautiful, loving person who had an active business in nail therapy. She had divorced her first husband solely because they had grown apart because of their respective businesses and from that marriage they had a son who is now in his late twenties. She had her own home and a car which suited her and suited her personality. She met the Perpetrator at a social evening and was immediately 'smitten' with him as he was with her. Within a very short space of time Trish announced that the Perpetrator was going to move in with her and it was at this stage that some of her friends thought that the relationship was going too quickly. It had already been noticed by friends that the Perpetrator was manoeuvring Trish away from the company of some of her friends.

Once he had moved in he was at variance with the neighbour and it is stated by some friends that acting in spite, the Perpetrator poisoned some of the neighbour's flowers with urine. The dispute reached a point when the Perpetrator told Trish that he felt like killing the neighbour.

After selling his own house the Perpetrator persuaded Trish they should buy another larger house in a village some miles away to which she agreed. This affected her business in that other than her most loyal customers, her clients would not travel to the new house. He then forbade Trish from using acrylic because he said it affected his asthma which again reduced her client income to almost zero. Both Trish and the Perpetrator would be invited to social evenings but Trish would make an excuse because she knew that the Perpetrator would drink excessively and embarrass her.

Throughout their marriage the Perpetrator coercively controlled all aspects of Trish's life but in fear of retribution, for a long time she didn't mention it to anyone and made excuses for her injuries which to her closest friends were clearly a result of domestic abuse. On occasions her friends would advise her to seek support and report the abuse but Trish minimised it and felt unable to do anything about it.

A significant piece of information came as a result of the Author visiting Trish's friends which revealed that the Perpetrator used a drone to monitor her whilst she was at home as well as when she drove away from her house. His possession of a drone is specifically confirmed by one of her closest friends who was aware the Perpetrator had bought one to fly over nearby hills and woods.

Analysis and Recommendations

Three recommendations are made in the Overview Report with respect of DACS:

Recommendation No1.

DACS review their referral process to include:

1a) Ensuring that referral forms are examined in detail and the appropriate risk assessment is made on the information available.

1b) In the case of a delay in DACS responding to a referral. The referring agency is to be informed by DACS of the delay with a special request that the referring agency advises the victim of the delay.

Recommendation No 2.

All agencies making referral to DACS for victims of domestic abuse ensure that referral forms are followed up and enquiries made of DACS as to;

a) the action DACS will be taking,
b) how any time delay and back log will affect the victim and
c) whether the referral is to be progressed by DACS or not thus enabling alternative support to be arranged by the referring agency.

It is without doubt that Trish reported the abuse to her GP to who she went on several occasions and informed the GP she was seeking a divorce from her abusive husband. The GP prescribed anti-depressants and failed to recognise the domestic abuse Trish was suffering. The GP failed to comply with the 2011 guidance issued by the Royal College of General Practitioners which stipulates a robust and proactive approach to victims of domestic abuse which consists of signposting, referrals and even a referral to MARAC. The following recommendation is made:

Recommendation No 3.

Warwickshire CCG's to ensure that all GP surgeries are compliant with the RCGP guidance issued in 2011, regarding adopting a more robust proactive approach towards domestic abuse within all GP surgeries.

In seeing eleven of Trish's friends the Overview Author asked each one about their knowledge of domestic abuse support agencies within Warwickshire and how they would go about signposting anyone who required such a service. Two of her friends said they would search the internet but none of them knew specifically where to obtain support, information or advice. This indicates a gap in the public's knowledge and therefore the following recommendation is made:

Recommendation No 4.

Warwickshire County Council to embark on a publicity campaign advertising by campaigns, posters seminars etc., the opportunities for victims of domestic abuse, their friends and family members in Warwickshire to locate help support and advice about domestic abuse support.

Recommendation No 5.

South Warwickshire Community Safety Partnership to liaise with the Solicitor's Regulation Authority and the Law Society to raise awareness of potential missed opportunities and to encourage the training of Solicitors acting in the divorce arena of law so as to enable victims of domestic abuse to receive appropriate legal advice and to be signposted to specialist domestic abuse support services.

Recommendation No. 6

Refuge to maintain contact with National Association of Estate Agents to ensure continued support from NAEA in the distribution of domestic abuse literature to victims of domestic abuse as and when necessary.

IMR Recommendations

As far as IMR recommendations are concerned there were no recommendations made by Warwickshire Police who had no contact with either Trish or the Perpetrator until the time of Trish's death and likewise the University Hospital Coventry and Warwickshire were in a similar position and make no recommendations.

Warwickshire CCG indicates that in this case the GP involved appears not to have conformed to procedures and policies that exist and the IMR Author makes the following comment:

'In undertaking this review it was apparent that the knowledge of GP Registrars in relation to patients disclosing domestic abuse requires attention'

The following recommendations are made:

1. Focused and targeted IRIS awareness improvement in General practice by the Advocate Educators / Clinical lead within Warwickshire. This will be an ongoing piece of work over the forthcoming year.
2. Re-circulation of the Duluth power and control wheel and RCGP Domestic abuse toolkit to all Warwickshire practices. This will be completed by 31.7.18.
3. Review of the training and education of Registrars in relation to Domestic abuse and IRIS. Discussions to be held by the 31.7.18
4. Warwickshire Clinical Commissioning Group Safeguarding Leads will review the GP self-assessment safeguarding tool to include assurance on domestic abuse interventions. To be completed by 30.9.18
5. Warwickshire Clinical Commissioning Group Safeguarding Leads, in partnership with the Named GP, will deliver a tailored safeguarding programme to all practice safeguarding leads to ensure they can deliver enhanced knowledge on domestic abuse. Dates to be disseminated to safeguarding practice leads by 31.7.18

6. Dissemination to all Primary care teams of the DASH risk assessment tool. To be completed by 31.7.18

Coventry and Warwickshire Partnership Trust mentions the Psychological Wellbeing Practitioner (PWP) who completed an assessment on Trish when she was requesting support with her depression. It was clear this was due to her abusive relationship with the Perpetrator and whilst the PWP referred Trish to IAPT the CWPT Domestic Abuse (Clinical) Policy requires the offer of a DASH risk assessment to be made for the victim. In that regard the CWPT IMR makes two recommendations:

1. In order to ensure that CWPT staff are able to recognise the importance of using the DASH to understand the history of abusive behaviours in the context of current risk, a formal agency recommendation is that a greater emphasis is given to this during CWPT Level 2 Safeguarding Training and CWPT Level 3 Domestic Abuse training.

2. Staff to be reminded via CWPT training that the 'all user' message facility should be made clear to patients at the beginning of any assessment and in the interests of continuity of care information will be shared with the client's GP. Patients can then make an informed decision about the information they share with the assessing clinician.

The South Warwickshire Foundation Trust record Trish attending to A&E with an injury that she said had been caused by her falling on a coffee table. There was no suggestion of domestic abuse however, on that occasion and a later occasion she attended A&E. There was no record of who accompanied her to the hospital. The IMR identifies three areas of learning from the Trust and in relation to domestic abuse and safeguarding training the trust makes two recommendations:

- South Warwickshire Foundation Trust are compliant with NICE Guidelines - Domestic violence and abuse Quality standard [QS116] Published date: February 2016 and will continue to report and monitor incidents relating to this area and to take learning from incidents.
- Safeguarding Adults training has been updated to provide increased information for staff regarding domestic abuse, how to recognise and how to engage with routine enquiry.

In addition to the recommendations made by the panel and agencies, the panel noted that there may have been a missed opportunity to signpost Trish towards a domestic abuse support/agency on the occasion that she went to her estate agent and explained why she wanted to sell the house. This may be pertinent to many victims of domestic abuse who wish to sell the family house or rent other accommodation because of domestic abuse situations.

With that in mind the Review Author and a Domestic Violence professional from the panel, arranged to meet the National Chief Executive of the National Association of Estate Agents with a view to seek cooperation in heightening the support available to victims of domestic abuse when they present at estate agents. The Chief Executive explained that the association had some 17,500 members across the UK which involved some 25,000 estate agent offices. The association also includes the rental market as well as house selling and purchasing, which, in domestic abuse situations is very relevant.

The Chief Executive agreed to ensure that domestic abuse was a focus for his association and that information would be included in a national two-weekly

newsletter, and a national bi-monthly magazine. He agreed to have advice and support leaflets for distribution in all outlets and had already arranged a meeting with his senior management to ensure domestic violence was part of the association's daily business. Arrangements are in hand to distribute leaflets, both nationally and locally through the association's public relations officer and the national press officer of the domestic abuse support charity. This initiative is seen as a significant step forward in spreading advice about the support available to victims of domestic abuse at a time when research indicates, they are at their most vulnerable.

Conclusions

The Perpetrator was a totally controlling and coercive man, who, married once, repeated his behaviour with his second wife, Trish, but to an even worse degree that resulted in him taking her life in a violent rage which was to end years of physical, emotional, financial and controlling abuse.

Trish was a woman who fell for the Perpetrator's charm and soon found herself besotted with her new partner and then husband. He moved in with her, according to her friends, in very quick time and immediately started to change her household possessions, her working locations, her financial arrangements, her earning potential and restricted her contact with her friends and social acquaintance's.

Trish had a wide circle of close and loyal friends most of whom felt uneasy about Trish's relationship with the Perpetrator for a variety of reasons, but what is common amongst them, is they all said that there was a feeling they had that things were not right and that Trish changed from the pleasant happy-go-lucky person she was, to a worried, anxious person who drifted away from their friendship. Some tried to give her advice and warn her of their feelings but she would not take any heed from their comments. To only a few did she confide about the Perpetrator's behaviour towards her. Some saw the result of the violence he inflicted on her, resulting in bruising and other injuries.

As time passed, Trish began to realise that the Perpetrator posed a real threat to her safety and quoted to some close friends the comments that the Perpetrator had made to her about intending to kill her or getting someone to do that for him. He made similar threats to an elderly neighbour over a dispute the Perpetrator had with him. Trish believed that the Perpetrator was capable of hurting the neighbour.

Eventually Trish summoned enough courage to do something about her life. She sought advice from a specialist divorce Solicitor, telling the Solicitor about her lifestyle and abusive relationship. It is understood that the Solicitor and Trish discussed the impact Trish reporting the Perpetrator's violence to the Police would have on his profession which may then have had an impact on the settlement Trish was likely to receive at the end of the divorce proceedings. It is also believed that the Solicitor also advised Trish against changing the locks of her doors thus preventing the Perpetrator's access. It is considered that this information was not accurate and in the circumstances Trish would have had ample justification to change the locks. The Solicitor did not signpost Trish to any support agencies and there did not appear to be any positive steps in exploring ways in which Trish could have pursued Civil proceedings against the Perpetrator in respect of his violence and abuse.

Some of Trish's friends are aware that Trish also reported details of her abusive relationship to her GP who made referral to IAPT. The referral form was passed to DACS. At that time due to the limitations of staffing, time and finance DACS were only funded to take on high risk referrals. At that time there was a twenty week waiting

list for referrals to be managed. This was not communicated to the referring agency, however it was not a standard procedure or policy for DACS. DACS are not a commissioned service, but a voluntary sector organisation with limited resources and capacity and they were not in a position to inform referring agencies when thresholds were not met. On a subsequent page of the referral form there was information to suggest that Trish's concerns were still ongoing even though the Perpetrator had left the house. She indicated she was frightened, especially at night time and would wedge the doors in case he tried to gain entry to the house and this was an ongoing fear. IAPT sent the referral document, however, DACS were not in receipt of the final page of the referral. Had this information been received it may have increased the risk level. Opportunities were missed to support Trish and to refer her to MARAC, for a multi-agency consideration of her situation.

Trish was locked in a situation where she felt that she could not report the matter to anyone. She was terrified of retributions being taken against her by the Perpetrator, even to the stage of being told by her closest friends not to marry him but being too frightened to tell him. There are many barriers to reporting abusive relationships, fear, anxiety, the loss of financial support, embarrassment and being left alone. There are many others. All of those mentioned Trish experienced and she felt that she had no one to turn to. In fact, she had a true circle of friends she could have turned to – some she did, but she did not take their advice for fear of the Perpetrator.

Even after Trisha and the Perpetrator had separated, he continued to keep her under observations. He used a drone as a surveillance tool. He made it clear that he had been inside her house whilst she had been out by moving items from one place to another. She would return home to find the lawn had been cut. His control over her was persistent and sinister. Because he could not get his own way over the sale of the house and because she stood up to him, he lost his temper and killed her in a brutal manner. Later at his trial he claimed diminished responsibility, a defence which the jury did not believe. He was convicted of Trish's murder.

There are several indications that opportunities to support Trish and to give her the correct advice by professionals were missed. However, there is nothing to say that had the correct advice been given to her, she would have acted upon it, but the fact is, the opportunity for her to listen to an independent professional's opinion of her situation was lost.

Terms of Reference

The aim of the Review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to the policies and procedures as appropriate;
- Prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working,
- Contribute to a better understanding of the nature of domestic violence and abuse : and

- Highlight good practice

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:

Victim:

- Was the victim recognised or considered to be a victim of abuse and did the victim recognise themselves as being an object of abuse?
- Did the victim disclose to anyone and if so, was the response appropriate?
- Was this information recorded and shared where appropriate?
- Were services sensitive to the protected characteristics within the Equality Act 2010 in respect of the victim and their family?
- When, and in what way, were the victim's wishes and feelings ascertained and considered?
- Is it reasonable to assume that the wishes of the victim should have been known?
- Was the victim informed of options/choices to make informed decisions?
- Were they signposted to other agencies?
- Was consideration of vulnerability or disability made by professionals in respect of the victim and Perpetrator?
- How accessible were the services for the victim and the Perpetrator?
- Was the victim or Perpetrator subject to a Multi-agency Risk Assessment Conference (MARAC) or any other multiagency forum?
- Did the victim have any contact with a domestic abuse organisation, charity or helpline?

Perpetrator:

- Was the Perpetrator recognised or considered to be a victim of abuse and did the Perpetrator recognise themselves as being a Perpetrator of abuse?
- Did the Perpetrator disclose to anyone, and if so, was the response appropriate?

- Was this information recorded and shared where appropriate?

- Was anything known about the Perpetrator? For example, were they being managed under MAPPA, did they require services, did they have access to services.

- Were services sensitive to the protected characteristics within the Equality Act 2010 in respect of the victim and their family?

- Were services accessible for the Perpetrator? And were they signposted to services?

- Was consideration of vulnerability or disability made by professionals in respect of the Perpetrator?

- Did the Perpetrator have contact with any domestic abuse organisation, charity or helpline?

Practitioners:

- Were practitioners sensitive to the needs of the victim and the Perpetrator, knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim or Perpetrator?

- Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

Policy and Procedure:

- Did the agency have policies and procedures in place for dealing with concerns about safeguarding and domestic abuse?

- Did the agency have policy and procedures for risk assessment and risk management for domestic abuse victims or Perpetrators (e.g. DASH) and were those assessments correctly used in the case of this victim/Perpetrator?

- Where these assessment tools, procedures and policies professionals accepted as being effective?

Individual Needs

Home Office Guidance[3] requires consideration of individual needs and specifically:

'Address the nine protected characteristics under the Equality Act 2010 if relevant to the review. Include examining barriers to accessing services in addition to wider consideration as to whether service delivery was impacted'

Section 149 of the Equality Act 2010 introduced a public sector duty which is incumbent upon all organisations participating in this review, namely to:

[3] Home Office Guidance 2016 page 36

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The review gave due consideration to all of the Protected Characteristics under the Act.

The Protected Characteristics are: age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief, sex and sexual orientation

There was nothing to indicate that there was any discrimination in this case that was contrary to the Act.

Engagement with the family

While the primary purpose of the DHR is to set out how professionals and agencies worked together, including how learning and accountability can be reinforced both in, and across, agencies and services, it is imperative that the views of the individual/family and details of their involvement with the DHR are included in this.

South Warwickshire Community Safety Partnership, through the Independent Chair, is responsible for informing the family that a DHR has been commissioned and an Independent Chair has been appointed. The DHR process means that agency records will be reviewed and reported upon; this includes medical records of both the victim and Perpetrator **if consent is agreed** by the Perpetrator.

Firstly, this is in recognition of the impact of the death of Trish giving family members the opportunity to meet the review panel if they wish and be given the opportunity to influence the scope, content and impact of the review. Their contributions, whenever given in the review journey, must be afforded the same status as other contributions. Participation by the family also humanises the deceased helping the process focus on the victim's and Perpetrator's perspectives rather than just agency views.

All IMRs are to include details of any family engagement that has taken place, or that is planned. The Independent Reviewer will be the single point of contact with the family in relation to the DHR in addition to the Police Family Liaison Officer, FLO, in respect of criminal proceedings.

In the event of media interest, all agencies are to use a statement approved and provided by South Warwickshire Community Safety Partnership.

It should be noted by all agencies that the DHR Overview Report will be published once completed, unless it would adversely impact on the adult or the family. Publication cannot take place without the permission of the DHR Home Office Quality Assurance Panel.

The media strategy around publishing will be managed by the DHR Panel in consultation with the chair of South Warwickshire Community Safety Partnership and communicated to all relevant parties as appropriate.

Consideration should be given by all agencies involved in regards to the potential impact publishing may have on their staff and ensure that suitable support is offered and that staff are aware, in advance, of the intended publishing date.

Whenever appropriate and 'Easy Read' version of the report will be published.

It is essential that all correspondence with identifiable information is sent via secure methods only. This would be via secure email account (GCSX) or through the Local Authority's Secure Communication System (SCS). Failure to do so will result in a data breach and must be reported to the Data Protection Commissioner.

The Domestic Homicide Review Officer will act as a conduit for all information moving between the Chair, IMR Authors, Panel Members and the DHR Panel.