Executive summary

THE REVIEW PROCESS

This Domestic Homicide Review (DHR) was carried out under section 9 of the Domestic Violence, Crime and Victims Act 2004, which came into force on 13th April 2011. It was mainly carried out under the terms of Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2011).

Adult A died in the Spring of 2012, and this was notified by Hampshire Police to the Chair of the Isle of Wight Community Safety Partnership (IWCSP) on the same day as it appeared that adult A had been stabbed by their spouse , adult B. Following further discussion, the Chair of the IWCSP decided to undertake a DHR and confirmation of that decision was sent to the Home Office a month after the original notification.

It is acknowledged that the DHR should then have been completed within six months unless there were complexities arising, typically around court processes. The final completion of the report therefore also considered the reasons for the delay in the process itself in order that these lessons be learned and addressed. These were around the departure of personnel involved, that there had been difficulty in identifying an appropriately experienced person and that those involved at the time did not appear to fully appreciate the importance and urgency around timescales for completing the review.

The multi-agency Review Panel was identified, including five agencies identified as relevant: GP, St Mary's Hospital medical services, mental health services, police and adult social services. Although health notes recorded adult A and adult B willingness to attend RELATE, there was no evidence of contact with that agency.

Terms of Reference were agreed, and the panel met a total of seven times. An independent Chair and report author was commissioned (SW) but although the first draft of his report was produced for the meeting on in spring 2013 and three further panel meetings to discuss it, the panel was unable to agree to the report. For personal reasons SW was then unable to conclude the review and in spring 2015 KB was commissioned to finalise the review.

SCOPE & METHODOLOGY

The Review considers agencies contact/involvement with adult A (the victim) and adult B (the perpetrator) from the time of a violent assault in 1992 until Spring 2012. It includes feedback from family, friends, employers and colleagues of victim and perpetrator, as well as agencies working with the victim and perpetrator.

It was confirmed that the only service which adult A was accessing prior to the homicide was that of their GP. Neither adult A nor adult B were receiving any service support relevant to the domestic abuse and therefore SW did not require any service to complete an Individual Management Review.

In his investigation, SW included face-to-face interviews, telephone interviews and reviewed all relevant documentation.

SW also met the IW Coroner in spring 2013 and discussed how the DHR could inform the inquest into the death of adult A.

Documents reviewed included hospital & GP medical records, social services records, police case summary and employment records.

BACKGROUND

Adult A and adult B met as teenagers and were married in the late 1970s. They had two children and always lived on the Isle of Wight. Both adult A and adult B had extensive extended families on the Island of Wight and were described by friends as "close and loving".

However, adult A and adult B had come to the attention of the police, health and social care agencies in 1992/3 following an incident of domestic violence. Despite adult A being hospitalised with significant injuries, the case was not brought to court. Adult B made a suicide attempt following the incident and was diagnosed with a depressive disorder with secondary paranoid psychosis. Adult B had no psychiatric history prior to 1992, but had received a custodial sentence in the early 1980s for violent offences. There is a suggestion that alcohol may have been an influence in these.

Adult B was discharged from mental health services in winter 1993. The family (adult A, adult B, their son and daughter) also received family therapy from social services until Summer 1993 when it stopped at the family's request. The closing summary from social services stated that all family members "know that services are available".

Beyond this, with the exception of some health services there were no other dealings with services or agencies between 1993 and 2012, including no evidence of domestic violence during that time.

In the process of investigation, the police were able to highlight an incident in 2008 which resulted in adult A leaving the family home and living with their son for several weeks. During that time adult A consulted their GP who prescribed sleeping pills. Adult A returned to the marital home a few weeks later.

One month before the homicide there had been a further incident ending in a minor fight between adult B and adult C over an alleged affair with adult A. However, none of this was known to agencies prior to the homicide.

Document checks revealed adult A had 15 attendances at St Mary's Hospital between 1977 and 2012. Of those, two in 1992 were a direct result of adult Bs violent assault on adult A, and adult A felt that three attendances 3, 5 and 13 years after the event were also related to the assault.

Of 31 visits adult A made to their GP between 1976 and 2012 only four between 2001 and 2011 appear to have any possible relevance, including back pain, frozen shoulder, stress and attacks of vertigo, dizziness and stress .

Adult B had 20 recorded visits to their GP between 1978 and 2012, (with a change of GP 1997). Of those after 1992 SW noted self-inflicted injuries to wrists and neck, 3 incidents of depression and one of paranoia, shortness of breath due to the effects of smoking marijuana and a visit to Accident & Emergency due to poke on the eye. Adult B was on the

Mental Health Register, with earlier mental health issues recorded "paranoid state in remission – nothing to note since 1992".

Of those family and friends who responded to the review, most were aware of the domestic difficulties described above, but with one exception, described an otherwise loving relationship. Despite acknowledging the strength of the love between the couple, one of adult A sisters, who considered herself estranged from the family, believed that adult A and Bs relationship had deteriorated following the 1992 incident, and recalled several other incidents but these could not be supported by medical or other records.

KEY ISSUES

Concerns around medical practice in 1992 are identified including the failure to do a psychiatric review on adult B when they were admitted for self-inflicted injuries in Autumn 1992, and that adult B was discharged from mental health services on in 1992 despite the confidential conversation between the consultant and family members which had revealed their concern that adult B would "do some serious violence if allowed out to family or wife. They do not rule out murder."

Much of the learning from the incident and involvement of agencies in 1992/3 has been addressed in the significant range of changes and improvements to the way that agencies address matters of domestic abuse and domestic violence examples of which have been included in the body of the report. There are Multi-Agency Risk Assessment Conferences (MARACs); there is a multi- agency Safeguarding Hub for Southampton, Hampshire, the Isle of Wight (Children only at present) and Portsmouth; LASB and LSCBs both of which have Independent Chairs; designated Domestic Violence Advisors and Domestic Abuse Co-ordinators both in the local authority, police. Safeguarding policies and procedures are also in place in the Clinical Commissioning Group.

The only agency involved with adult A and adult B between 1992 and 2012 was their GPs. There may have been an opportunity for her GP to identify a potential risk to adult A in winter 2009 when they presented with stress, stating that their marriage was over. However with those GPs retired, the review could not take account of GP accounts and only had reference to the recorded history.

Adult A's medical records were not 'flagged' for domestic abuse issues which is now standard practice on the IW where known cases of domestic abuse are 'flagged' on the victim's and perpetrator's GP medical records (including the children's medical records). Adult A's medical record was not 'flagged' retrospectively when the GP Practice computerised all its records around 10 years ago. However adult A's GP Practice takes domestic abuse very seriously and were not aware of any domestic abuse issues in the last 12 years since their long-standing GP retired.

Police and social services records were no longer available for review which, although in line with organisational policies at the time, meant that the DHR could not accurately reflect all the details associated with the earlier incident in 1992.

The lack of contact with agencies between 1992 and 2012 means that there was no way for any of those agencies to have recognised any increased risk to adult A.

Any warning signs immediately prior to the homicide, in the shape of incidents in 2008/9 and spring 2012, were not recognised by family or friends/colleagues and none were reported to the DHR either directly or indirectly.

RECOMMENDATIONS

Local recommendations include:

- Addressing systems for recording incidents of domestic abuse and improve recording practice
- The value of GP representation on IWs Multi-Agency Risk Assessment Conferences (MARAC).
- The IWCSP launch an awareness campaign for professionals and general public, as well as specifically emphasising to families the importance of seeking support if they believe there are risks to relationships and mental wellbeing

Nationally, the review concludes that it would be beneficial if the role of GPs was more explicit in terms of DHRs as there were some concerns around confidentiality of records and appropriate involvement.

Finally, in order to address failings in terms of the review process itself, there are recommendations that future reviews should ensure there is an Individual Management Review (IMR) from any service including primary medical involvement (GP), that IWCSP makes sure members are fully aware of the importance and process of DHRs, and that the lead reviewer/report author should be a separate role from the Chair, who should take responsibility for ensuring timely completion.