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DHR 2016K Executive Summary
Month and Year of death: August 2016

Domestic Homicide Review
Safer Lincolnshire Partnership

Independent Author and Chair: Hayley Frame

Report Dated: 17th May 2018

Contents

1. The Review Process

1.1. The establishment of a Domestic Homicide Review (DHR) is set out under Section 9 of the Domestic Violence Crime and Victims Act 2004 which came into force on the 13th April 2011.

1.2. This summary outlines the process undertaken by Safer Lincolnshire Partnership domestic homicide review panel in reviewing Peter who was a resident in their area. The following pseudonyms have been used in this review for the victim and perpetrator to protect their identities and those of their family members: Peter and Janet.

1.3. Criminal proceedings were completed pleaded after the perpetrator pleaded guilty to the manslaughter of Peter on 21st December 2016.

1.4. The decision to undertake a Review was made by Safer Lincolnshire Partnership on 13th September 2016. All agencies that potentially had contact with the victim and/or perpetrator prior to the point of death were contacted and asked to confirm whether they had involvement with them. Agencies that confirmed contact with the perpetrator and/or victim were asked to secure their files.

2. Contributors to the Review

2.1. Agencies participating in this Review and commissioned to prepare Individual Management Reviews/summary reports are:

- Lincolnshire Community Health Services NHS Trust
- United Lincolnshire Hospitals NHS Trust
- Lincolnshire Police
- GP practice
- East Midlands Ambulance Service
- The District Council

Individual Management Review authors were all independent from any direct management of the case.

Unsuccessful attempts were made to engage with the family of the victim and also to engage the perpetrator in the Review process. This was in order to seek their contribution to the review. Information obtained from statements given with the criminal investigation process has helped provide some perspectives of family and friends. It is acknowledged that due to the circumstances not all families feel able to contribute to the DHR process.

3. The Review Panel Members and Author of the Overview Report

3.1. DHR Panel members consisted of senior representatives from the following agencies:

- Lincolnshire Community Health Services NHS Trust
- United Lincolnshire Hospitals NHS Trust

- Lincolnshire Police
- GP practice
- The District Council
- CCG

3.2. In addition, the DHR panel had a legal advisor, a Domestic Abuse Project Officer and DHR Administrator.

3.3. The Independent Author/Chair is a qualified and HCPC registered Social Worker having qualified in 1995. Since 2010, she has authored serious case reviews, safeguarding adults reviews and domestic homicide reviews. This is the 7th domestic homicide review completed by Hayley. She has had no connection with the Community Safety Partnership or with any of the agencies involved in the Review.

3.4. The DHR panel met on 4 occasions. All panel members were independent from the direct line management of the professionals who had contact with the victim and /or perpetrator.

4. Terms of reference for the review :

4.1. The following areas were addressed in the Individual Management Reviews and has shaped the analysis of the Overview Report:

a) To examine whether there were any previous concerns, incidents, significant life events or indications which might have signalled the risk of violence to any of the subjects, or given rise to other concerns or instigated other interventions.

b) When, and in what way, were practitioners sensitive to the needs of the subjects, 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?

c) When, and in what way, were the subject's wishes and feelings ascertained and considered? Were the subjects informed of options/choices to make informed decisions? Were they signposted to other agencies and how accessible were these services to the subjects?

d) What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

e) Was appropriate professional curiosity exercised by those professionals and agencies working with the individuals in the case, this includes whether professionals analysed any relevant historical information and acted upon it?

f) Were the actions of agencies in contact with all subjects appropriate, relevant and effective to the individual and collective family needs and risks identified at the time and continually monitored and reviewed?

g) Did the agency have policies and procedures for Domestic Abuse and Safeguarding and were any assessments correctly used in the case of the subjects? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC or other multi-agency fora?

h) Did actions or risk management plans fit with the assessment and decisions made? 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?

i) Were any issues of disability, diversity, culture or identity relevant?

j) To consider whether there are training needs arising from this case

k) To consider the management oversight and supervision provided to workers involved

l) Did any restructuring, during the period under review, likely to have had an impact on the quality of the service delivered?

5. **Summary chronology**

5.1. In December 2012, Peter attended the Accident and Emergency Department with a laceration to the left side of his chest. He reported being drunk at the time of the injury and wearing inappropriate footwear when he fell onto a fence. Peter reported living alone and named his mother as his next of kin. He reported a history of problematic alcohol use. The injury was deemed to be consistent with the account given and was sutured and dressed. Peter was admitted overnight for observation but discharged the next day.

5.2. In June 2014, it was recorded by the Council Benefits office that Peter had moved property, where he was residing alone. Information recorded indicates that Peter was having his housing benefit and Department of Work and Pensions Benefits paid into the account of Janet.

5.3. Peter attended his GP in July 2014 with a small hematoma to his abdominal wall. No history of trauma was given and as such routine bloods were ordered. Peter was noted to still be alcohol dependent. The blood tests indicated no abnormalities with regard to clotting but were consistent with alcohol dependency.

5.4. At a review GP appointment held in August 2014 a discussion took place regarding Peter's alcohol dependence. He was given an information leaflet regarding self-referral to Addaction – a drug and alcohol specialist service.

5.5. Peter attended the minor injuries unit with a painful foot in August 2015. It was assessed as a possible fracture and he was advised to attend the Accident and Emergency Department. The nurse practitioner documented that he smelt strongly of alcohol.

5.6. Peter attended the minor injuries unit again in August 2015 with a swollen upper left eyelid. He was seen by the same nurse practitioner. Peter reported having been hit with a TV remote control 2 days previously.

5.7. Peter attended his GP again in May 2016 requesting a referral back to the spinal department for chronic back pain. It was recorded that Peter reported being back on the Addaction programme and so his drinking was reduced.

5.8. In August 2016, Peter died as a result of a stab wound.

Key issues arising from the review

5.9. Identification of domestic abuse

5.10. It is clear from this review that there was minimal information held by agencies in respect of Peter and Janet, and even less so with regard to them as a couple. Both individuals were seen by health agencies, although they were generally seen separately and on an irregular basis. Although they were registered at the same GP practice, they were not known to be in a relationship and were registered at separate addresses. There were no records of agency concern with regard to domestic abuse between the couple.

5.11. Although Peter did come to the attention of health agencies with a number of minor injuries, these appeared to be seen in the context of an individual with a known alcohol problem. He did not disclose domestic abuse to any professional and his self-reporting was accepted as accurate and truthful. The review has considered whether professional assumptions are made regarding people with alcohol and substance use difficulties, in that they may be more prone to accidental injury. The need for professional curiosity must continue to be reinforced via training and awareness raising.

5.12. When Peter attended the minor injury clinic in August 2015 with a swollen and bruised eye, having been hit by a TV remote control, enquiries were not made regarding who had thrown the remote control. It would have been expected practice for staff to have made further enquiries.

5.13. Within LCHS now, all practitioners must complete induction training prior to any clinical practice, and this induction training includes safeguarding children and adults with domestic abuse elements, such as professional curiosity, completion of DASH Risk Identification Checklist and referrals to MARAC. In addition, quarterly group safeguarding supervision is available to those working within the minor injuries unit.

5.14. Referrals for support services

5.15. A number of agency records refer to Peter's substance use, particularly problematic alcohol use. Despite Peter's many reports of engagement with Addaction, there is no evidence of him being in receipt of specialist alcohol support services to address his problematic alcohol use. He was given information by the GP practice for self-referral but would appear never to have self-referred. It is recognised that Peter would have needed to be motivated to address his problematic alcohol use.

5.16. Within hospital contacts, problematic alcohol use was recorded and relevant lifestyle advice was provided but direct referrals for support services were not made which would have been a more robust response. Action has been taken to address this.

5.17. Janet is not identified in any agency records as having problematic alcohol use, although this would seem to be the case given the findings of the criminal trial.

5.18. There is no evidence of any referral being made in relation to domestic abuse support services for either Janet or Peter as domestic abuse was not an area of concern.

5.19. **Agency policy, procedures and practice**

5.20. The majority of agencies involved appeared to have appropriate policies and procedures in place with regard to safeguarding and domestic abuse. At the time of the incident, the GP practice had poor policies in place, and has recognised that practitioners were unaware of the potential indicators of domestic abuse. Again, action has? been taken to address this.

5.21. There is evidence of interagency communication however the Review has considered how there is often no duty to share information within the wider health community and that inter-agency health communication can face limitations given the ways that services are commissioned. Forexample, it might be assumed that if Peter had attended Addaction then the GP would have been made aware. This is not the case in practice. This challenge has been drawn to the attention of local commissioners.

6. Conclusions and lessons learned

6.1. With regard to positive agency practice, the Review has commended the actions of the GP in this case who tried hard to engage and support Peter with regard to his vulnerabilities and problematic alcohol misuse. The Review recognised the restrictions of Peter's self-reporting and his perceived lack of motivation to change which frustrated efforts to engage Peter.

6.2. There was no agency knowledge of the relationship between Janet and Peter and no reported concerns regarding domestic abuse. There is very little sense of their relationship as a result and this has been an area of difficulty for the review. The lack of family engagement has significantly impacted upon this review although it has been able to consider the sentencing remarks made following the conclusion of the criminal trial.

6.3. Information obtained within the criminal investigation would suggest that Peter only confided in his mother and son about the volatility and violence within his relationship with Janet. An area of learning is therefore with regard to how families and friends can be encouraged to seek help and advice if they have concerns that someone close to them is being abused. Community awareness campaigns are a key area for development. This was echoed by the Home Office Analysis of DHRs which states that the full extent of the violence often only came to light during the police investigation into the homicide revealing that friends, family and neighbours knew about the abuse but either did not know what to do about it or were asked by the victim to not report it. It was quoted from one DHR that these individuals held more information than agencies around the nature of the relationship between the victim and perpetrator.

6.4. Peter presented with minor injuries and his explanations were accepted. Although there is no evidence of this within agency records, the Review has considered how practitioners might be influenced in their judgement in the context of an individual reporting injuries who is known to have problematic alcohol use and whether this leads to assumptions being made.

6.5. That said, and as identified within the IMR written on behalf of the couple's registered GP practice, with little knowledge or disclosure of any relationship between Peter and Janet, professionals were sadly unable to predict or prevent the death of Peter.

7. **Recommendations from the Review**

7.1. All agency IMRs recommendations are submitted as an appendix to this Review.

a) Community awareness campaigns should be considered with a focus on how families and friends can be encouraged to seek help and advice if they have concerns that someone close to them is being abused or is an abuser.

b) The example of good practice with regard to the process to be followed in situations where benefits are paid into the account of someone other than the claimant is to be shared within all of the District Councils within Lincolnshire.

c) The findings of this Review will be shared with local Commissioners and particular reference will be made regarding the need for commissioned services to meet the needs of both male and female survivors of domestic abuse.

d) The findings of this review will also be shared with national research agencies who have a focus upon male victims.