DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

Into the death of

Susan

Chair: David Hunter

Author: Carol Ellwood

Date: February 2022

CONTENTS

1. THE REVIEW PROCESS

1.1 This executive summary outlines the process taken by Safer Lincolnshire Partnership following the death of Susan. It includes Susan's story, the views of her family and ends with learning and recommendations.

1.2 The following pseudonyms agreed with Susan's family are used within the report.

Name	Relationship	Age	Ethnicity
Susan	Partner of Ben	47	White British female
Ben	Partner of Susan	33	White British male
Child 1	Susan's eldest child	n/a	White British
Child 2	Susan's second child	n/a	White British
Child 3	Susan and Ben's child	n/a	White British

1.3 Susan was the partner of Ben. Susan died from a head injury sustained during a road traffic incident. At the time of her death Susan was a passenger in a motor vehicle being driven by Ben.

1.4 The report was seen by Susan's family who provided the following tribute – 'Susan was a loving Mum, daughter and sister, who was tragically taken from the world too soon. Although a very private and reserved person, she cared for everyone and was always willing to do her best and help others. She will not see her children grow up, especially her youngest child who was so young at the time of Mum's death. It has been hard on the family to come to terms with the loss of Mum and leaves so many questions that we cannot answer. As a family we think about Mum every day and miss her so much'.

1.5 The panel offers its condolences to Susan's family.

1.6 HM Coroner recorded the following narrative verdict - 'The deceased was travelling in the front passenger seat of a vehicle being driven by her partner. The pair were arguing; the deceased expressed some concern as to the manner in which the vehicle was being driven and asked him to stop or slow down. When this did not happen, she opened the door and threw herself from the vehicle which at that point was travelling at a minimum speed of 36 mph. There is no evidence that she sought to end her own life

and it is not clear whether she appreciated the risks involved in what she did'.

2. CONTRIBUTORS TO THE REVIEW

2.1 The following agencies provided information to the review.

We Are With You (Formerly 'Addaction')	East Midlands Ambulance Service
GP[1]	Humberside, Lincolnshire and North Yorkshire Community Rehabilitation Company
Lincolnshire Children's Services	Lincolnshire Police
Lincoln Partnership NHS Foundation Trust	North Kesteven District Council [Housing]
United Lincolnshire Hospitals NHS Trust	West Lindsey District Council

2.2 Susan's family were seen as part of the review and their contribution is incorporated within the report. Ben was seen as part of the review and his contribution is included as appropriate. Ben's Mother, who was close to Susan also provided information for the review.

[1] Chronologies were received from two GP Practices and an IMR, incorporating a chronology from a third GP Practice. There was no requirement for the two GP Practices to produce an IMR.

3. THE REVIEW PANEL MEMBERS

Name	Job Title	Organisation
Tracy Aldrich	Housing Services Manager	North Kesteven District Council
Liz Bainbridge	Consultant Nurse Safeguarding Children & Mental Capacity	Lincolnshire Partnership Foundation Trust
Carol Ellwood	Author	Independent
David Hunter	DHR Chair	Independent
Jane Keenlyside	Senior Management Team	EDAN[2] Lincolnshire
Barbara Mitchell	Head of Safeguarding	Lincolnshire Community Health Services (Attended first two panel meetings).
Matthew Morrissey	Interchange Manager and Lead for Safeguarding Children and Adults	Humberside, Lincolnshire and North Yorkshire Community Rehabilitation Company
Sarah Norburn (Deputising for Jon McAdam – Head of Protecting Vulnerable People)	Domestic Abuse Co-ordinator	Lincolnshire Police

[2] https://edanlincs.org.uk/

EDAN Lincs (Ending Domestic Abuse Now in Lincolnshire) Domestic Abuse Service (formerly West Lincolnshire Domestic Abuse Service) is a registered charity; we provide support and assistance to women, men and children suffering, or fleeing from domestic abuse. EDAN Lincs Domestic Abuse Service (EDAN Lincs) provides safe, emergency, temporary accommodation and support to any male or female – with or without children – experiencing domestic abuse. Whilst we do not have accommodation for males in our multi-occupancy refuge, we do offer support to men experiencing domestic abuse in our dispersed properties and via Outreach Support.

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Karen Ratcliff	Lincolnshire Service Manager	We Are with You
Claire Saggiorato	Lead Nurse Safeguarding	Lincolnshire Children's Health
Yvonne Shearwood	Head of Service	Lincolnshire Children's Services
Elaine Todd	Named Nurse for Safeguarding Children and Young People	United Lincolnshire Hospitals NHS Trust
Claire Tozer	Safeguarding Adults and Children Lead	Lincolnshire Clinical Commissioning Group
Natalie Watkinson	Domestic Abuse Project Officer	Lincolnshire County Council
Safer Lincolnshire Partnership Support		
Toni Geraghty	Legal Advisor	Legal Services Lincolnshire
Jade Sullivan	Community Safety Strategic Co-ordinator with a lead in Domestic Abuse	Lincolnshire County Council
Teresa Tennant	DHR Administrator	Lincolnshire County Council
Observers[3]		
Lara Iggulden	IDVA Manager	EDAN Lincolnshire
	GP Practice Manager	

3.1 The Chair of Safer Lincolnshire Partnership was satisfied that the Panel Chair was independent. The Panel Chair believed there was sufficient independence and expertise on the Panel to prepare an unbiased report.

3.2 The panel met six times and the review chair was satisfied that the members were objective and did not have any operational or management involvement with the events under scrutiny. There were no reported conflicts of interest.

[3] Observers were present during a number of the DHR Panel meetings for their continuing professional development.

4. CHAIR AND AUTHOR OF THE OVERVIEW REPORT

4.1 On 19 October 2018 Safer Lincolnshire Partnership determined the criteria for a Domestic Homicide Review had been met, and thereafter appointed David Hunter as the Independent Chair and Carol Ellwood as the Independent Author, both of whom are independent practitioners.

4.2 David is an independent practitioner who has chaired and written previous Domestic Homicide Reviews, Child Serious Case Reviews, Multi-Agency Public Protection Reviews and Safeguarding Adults Reviews and was judged to have the experience and skills for the task. Before retiring from full time work in 2007 he served in the armed forces and police service. He did not serve in Lincolnshire.

4.3 Carol retired from thirty years public service [British policing] during which she gained experience of writing independent management reviews, as well as being a panel member for Domestic Homicide Reviews, Child Serious Case Reviews and Safeguarding Adults Reviews. In January 2017 Carol Ellwood was awarded the Queens Police Medical (QPM) for her policing services to Safeguarding and Family Liaison. Carol is also an Associate Trainer for Safelives[4].

[4] http://www.safelives.org.uk/ The UK-wide charity dedicated to ending domestic abuse, for everyone and for good.

5. TERMS OF REFERENCE FOR THE REVIEW

The review covers the period 1 March 2015 [which was the date Susan booked for ante-natal care for Child 3] until 19 September 2018.

5.1 **The purpose of a DHR is to**:[5]

a] 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;

b] 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;

c] Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

d] Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

e] Contribute to a better understanding of the nature of domestic violence and abuse; and

f] Highlight good practice.

SPECIFIC TERMS

1. 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.

2. 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 Susan, Child 3 or Ben? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

[5] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2016] Section 2 Paragraph 7

3. 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?

4. 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?

5. 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?

6. 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?

7. 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 Susan subject to a MARAC or other multi-agency fora?

8. 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?

9. Were any issues of disability, diversity, culture or identity relevant?

10. To consider whether there are training needs arising from this case?

11. To consider the management oversight and supervision provided to workers involved?

12. Was any restructuring during the period under review likely to have had an impact on the quality of the service delivered?

6. SUMMARY CHRONOLOGY

6.1 Susan

6.1.1 Susan was the eldest of two children born to her parents. During her childhood Susan lived in villages surrounding Lincoln where she attended local schools. Upon leaving school Susan had several jobs within the catering industry and progressed within this area to undertake roles at Assistant Manager level for several years. Susan was also known to have a domestic cleaning job, which had been gained through contact with Ben's Mother.

6.1.2 Susan had two children from a previous relationship. These children lived with their father following the separation of the relationship. The eldest of these children lived with Susan and Ben in the months prior to her death. Susan was described by her family as a very private and reserved person. Susan's family stated that prior to her meeting Ben, she always took pride in her personal appearance and ensured that her house was spotlessly clean and tidy, a position that deteriorated as her relationship developed with Ben. This change was described, by a family member, as if Susan had done a complete '360' degrees.

6.2 Ben

6.2.1 Ben is the youngest of five children. Ben worked on road building/repairs and more latterly he qualified to drive lorries. Ben worked long hours and often worked away from home. Ben informed the review that he had used drugs since about the age of 15 and that he was aware of the effect on his mental health with this long-term use. Ben stated that for the first two years of his relationship with Susan she was not aware of his drug use. Ben stated he did not drink much alcohol, other than an occasional bottle of beer.

6.2.2 Susan's family described Ben as someone who very rarely consumed alcohol, but when he did, he went over-the-top. Susan's family described Ben as a jealous person, who could easily change his behaviour and that he presented with an aggressive stance and had no respect for statutory authorities. Ben acknowledged to the review that he had a short temper and could easily 'blow up'. Ben has several convictions that are relevant for this review.

6.3 Susan and Ben's Relationship

6.3.1 Susan and Ben are understood to have met around July/September 2014 and on seeing each other they formed an immediate attraction. Ben informed the review that he was not in a good place when he met Susan and had had a diagnosis of depression, however; this soon lifted after he met Susan and found work. Ben described their relationship as 'spot on' and that they got on well, which continued after their child (Child 3) was born. Ben's Mother informed the review that there was verbal and physical aggression (pushing and shoving) in the relationship, which she described as being 'six of one and half a dozen of the other'.

6.3.2 Two months prior to the death of Susan, the Police responded to a domestic incident, during which Susan was assaulted by Ben. Child 3 was present during the incident. Ben was arrested and later released without charge.

6.3.3 Four months before Susan's death, Child 1 moved into the family home, the dynamics changed, and Ben began niggling at Susan. Child 1 informed the review that in the 2-3 weeks prior to Susan's death, she appeared to be quiet and she had asked Child 1 not to disclose to the family the arguments that were happening and how things were in the home between her and Ben.

6.3.4 Accommodation and finances were an issue in the relationship. Susan and Ben moved out of a private rental property, owing money, which resulted in a court case. From here, the couple initially moved to a touring caravan, before moving into a static home in a rural part of Lincolnshire, away from the village they had previously lived in. In the two weeks before Susan's death, Susan and Ben had moved into a flat above the disused pub on the site, in which they were living.

6.3.5 Susan's family felt that although their move out of the village was due to the condition of their rental property, on reflection since Susan's death, they felt it may have been a way of Ben isolating Susan from her family.

6.3.6 Susan's family often lent her money during her relationship with Ben. The money was never repaid. Susan's family believed that Ben controlled the finances. In contradiction, Ben stated that his wages were paid into Susan's bank account, from which he was provided with an allowance, as Susan had the bank card. Ben's Mother informed the review she had received letters at her property, for Susan which related to financial matters.

6.4 Information known to Statutory Agencies

6.4.1 Ben had been involved in domestic abuse in previous relationships. In 2009 Ben was convicted for an offence of battery. This was Ben's only conviction for a domestic abuse related crime. It was also known that Ben sometimes resorted to violence when in conflict with other people in a non-domestic setting this included unprovoked attacks on strangers.

6.4.2 There was evidence within some agency records that there had been domestic abuse in Susan and Ben's relationship in the four months prior to Susan's death.

6.4.3 In June 2018 Ben assaulted Susan and was arrested. Susan reported that Ben had 'head-butted' her during the incident. Child 3 had been present. Ben's previous involvement in domestic abuse was not considered as part of wider safeguarding measures.

6.4.4 In August 2018 Susan informed several agencies of the domestic abuse within her relationship with Ben and the concerns she had for Ben's mental health. Ben was referred to mental health agencies. Susan was provided with information on how to access support. Agencies recognised the impact of domestic abuse in the relationship and referred their concerns to Children's Social Care. Agencies response to these concerns was appropriate and in accordance with policies and procedures.

6.4.5 In January 2019 Ben appeared at Lincoln District Magistrates' Court charged with motoring offences which occurred at the time of the road traffic incident resulting in Susan's death. Ben pleaded guilty to those offences and was disqualified from driving.

7. KEY ISSUES ARISING FROM THE REVIEW

7.1 Susan had told some professionals that she knew about Ben's history of domestic abuse, but the review identified that professionals did not check her understanding of what she knew, from Ben, or other non-official sources, against the facts.

7.2 Susan had confided in an individual family member in the months prior to her death about her poor and sometimes violent relationship with Ben and swore the person to secrecy. From information provided to the review, the relationship between her and Ben had deteriorated at an escalating pace prior to Susan's death.

7.3 There were opportunities during the timescales of the review for agencies to consider additional safeguarding measures such as utilising DVDS and DVPN procedures. Research of historical information was also not undertaken to inform risk assessments. Engagement with Ben did not take place to inform assessments and safety planning.

7.4 Professionals had provided Susan with information on support agencies and how to access support. Children's Social Care developed a safety plan with Susan. Susan did not seek help and support for her relationship with Ben. Susan's did not have a true understanding of the identified risks for her to be able to manage the risks for her and Child 3.

7.5 The panel considered the decision of the family to move to an isolated location and determined that this was an emergence of control in relation to isolation for Susan. Control and coercion, including financial exploitation are often a feature in domestic homicide reviews; however, despite known financial difficulties for Susan, the DHR panel could find no evidence that this was linked to control and coercion by Ben.

7.6 Ben acknowledged that he had treated Susan unfairly. The DHR Chair asked Ben what could have been done to help them. Ben stated that he should have left the relationship adding that Susan had not asked him to leave or told him that she was leaving their relationship. The panel thought that Ben's use of the phrase, 'Susan had not told him to leave' demonstrated his lack of insight into domestic abuse, his minimisation of events and victim blaming.

7.7 Whilst there have been no criminal charges directly related to the death of Susan, Safer Lincolnshire Partnership, determined the death met other elements of the domestic homicide review criteria. They commissioned this

Domestic Homicide Review to analyse agency involvement, in order to identify if domestic abuse was known to agencies before the death of Susan, and, where known, to review how those agencies responded to those concerns in order to identify any learning within the Safer Lincolnshire Partnership.

8. LEARNING IDENTIFIED

8.1 The DHR panel identified the following learning. Each point is preceded by a narrative which seeks to set the context within which the learning sits. Where learning leads to an action a cross reference is included within the header.

Learning 1 [Panel recommendation 1]
Narrative
Susan informed Professionals that she was aware that Ben had been involved in domestic abuse in previous relationships and that she was aware of the signs of domestic abuse and what action could be taken. Professionals did not check Susan's level of knowledge with the facts and therefore did not identify whether there was a gap in her knowledge that could have impacted on her decisions about keeping herself and Child 3 safe.
Learning
Professionals need to ensure that victims of domestic abuse have good quality information about keeping themselves safe and are supported in the decisions they make.

Learning 2 [Panel recommendation 2]
Narrative
There are processes and legislative options which allow Professionals to disclose information to victims on risks and convictions in order to safeguard themselves and their family. These include social care assessments, Section 47 and Section 17 Children Act assessments, Child Sex Offender Disclosure Scheme (CSODS)[6] and assessments within the Probation Service. In addition, there is also the option of Professionals utilising the Domestic Violence Disclosure Scheme to which any agency can make an application/refer a case.
Learning
In order to protect victims, professionals working in this field need to have a clear understanding of the availability of civil orders, different processes and legal options available to them to undertake disclosure, including accessing the DVDS.

[6] https://www.gov.uk/government/publications/child-sex-offender-disclosure-scheme-guidance

Learning 3 [Panel recommendation 3]
Narrative
Susan confided in a family member about her relationship with Ben in the months prior to her death. It was only after Susan's death that the family considered that there may have been domestic abuse within the relationship. The family informed the DHR Chair and Author that they felt that communities are not aware of what to do should they suspect domestic abuse and which agencies they can contact to raise their concerns.
Learning
Publicity campaigns on domestic abuse need to ensure that they reach all aspects of the community, including families, friends and work colleagues and provided them with information on the stages of domestic abuse, and coercive control, how they can respond and report concerns. In addition, information also needs to detail civil options available including how information can be requested and shared under processes such as DVDS.

8.2 Agencies Learning

There are no individual agency recommendations as learning has been embedded into practice and any relevant changes to processes undertaken prior to the completion of the review.

8.2.1 We Are With You

Identified compliance with the policy for clients who do not attend appointments; keep adequate records on data system and gather enough information to sufficiently inform risk assessment.

8.2.2 Humberside, Lincolnshire and North Yorkshire Community Rehabilitation Company

Improvement with pre-sentence processes including checking of service records and articulation of clinical assessment of risks and not to solely rely on numeric tools such as RSR (Risk of Serious Recidivism). All staff have received a reminder regarding the importance of both areas of learning.

8.2.3 Lincolnshire Children's Services

Recording keeping with health visiting records. Social worker engagement with males during assessment, which has been addressed directly with the

practitioner. Lincolnshire Children's services say, 'the issues raised by this matter are addressed within the internal procedures. There has been work undertaken with the individuals who were involved in this matter which took place prior to the commencement of this review. It is accepted that there is always a risk that individuals will not comply with the set procedures and when this takes place this is addressed through the internal quality assurance processes. Consequently, there are no recommendations.'

8.2.4 Lincolnshire Police

Further training around DVDS and DVPN/O has been undertaken. Upgrades have taken place in relation to PPN/DASH risk assessments and prompts for research on previous history.

9. RECOMMENDATIONS

9.1 The DHR panel identified the following recommendations.

Number	Recommendation
1	That the Safer Lincolnshire Partnership obtains evidenced based assurances from its core membership that staff working in this field know the importance of checking a victim's full understanding of risk factors particular to their circumstances.
2	That the Safer Lincolnshire Partnership obtains evidenced based assurance from its core membership that staff working in this field have a clear understanding of the different processes, civil orders and legal options available to all agencies to undertake a disclosure of information to a victim.
3	That the Safer Lincolnshire Partnership reviews the existing Domestic Abuse Communications Plan to raise awareness of domestic abuse in Lincolnshire. Ensuring it is reaching all aspect of the community, including family, friends and work colleagues, on how they can respond and report concerns and options available to them, including civil orders and how they can request information to inform their safety planning.