West Berkshire Safer Communities Partnership

DHR Overview Report Executive Summary

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1. Introduction

This Domestic Homicide Review (DHR) examines the circumstances surrounding the unexpected death of SH in Newbury, Berkshire in August 2014. The DHR was commissioned by the Community Safety Partnership of West Berkshire District Council.

The DHR was commissioned by the Community Safety Partnership of West Berkshire Council in September 2014. On 17th August 2014, SH was found deceased at the home she shared with her husband Adult B by police and paramedics.

On 20th February 2015 at Reading Crown Court, Adult B was found guilty of manslaughter of SH on the grounds of diminished responsibility and sentenced to six years in prison.

The report and this Executive Summary uses the initials SH to denote the victim in this case. The initials represent her first name and maiden name. The decision to adopt this approach was taken after discussion with family members and their advocate. It was taken to maintain confidentiality but also to be more personal to her rather than using random initials or other forms of anonymisation.

2. The DHR process

A DHR was recommended and commissioned by the Community Safety Partnership in September 2014 in line with the expectations of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2011. This guidance is issued as statutory guidance under section 9(3) of the Domestic Violence, Crime and Adults Act 2004.

A panel met for the first time on 5 November 2014 following the appointment of an independent Chair and at that meeting the independent author was appointed. That meeting also agreed the Terms of Reference and agreed that the DHR would also serve as a Mental Health Homicide Review. It was also agreed that the DHR would seek to satisfy the standards and requirements of a Vulnerable Adult Serious Case Review.

The DHR Panel received and considered Individual Management Reviews (IMRs) from the following agencies:

- Thames Valley Police
- West Berkshire Council
- Newbury & District Clinical Commissioning Group
- Berkshire Healthcare NHS Foundation Trust
- South Central Ambulance Service NHS Foundation Trust
- Sovereign Housing Association
- A2Dominion

3. Views of the family

Throughout the review the panel has sought to ensure that the wishes of the surviving family members have informed its work and that their views are reflected in the Overview Report.

The engagement with family members of both SH and Adult B has taken place through email, telephone contact and face-to-face meetings.

In relation to Adult B, the views of his ex-wife and his daughter were gathered through face-to-face meeting with the co-chairs and they have been kept informed of progress with the DHR.

In relation to SH, the views of her two sisters were gathered through a face-to-face meeting with the co-chairs and they have been kept informed of progress with the DHR.

SH's eldest son, SW has met face-to-face with the co-chairs and the panel co-ordinator once and with one of the co-chairs and the panel co-ordinator once.

At the conclusion of the review the sisters of SH and her eldest son and his wife met with the co-chairs, having reviewed the draft report in order to make further inputs to the final version of the report.

4. Involvement with the perpetrator

The co-chairs wrote to Adult B to inform him about this DHR and to seek his views about engaging with the DHR process. Adult B was willing to be interviewed as part of the process and the co-chairs met with him in prison in May 2015. Adult B has been kept informed of the progress of the review.

5. Conclusions

Having reviewed and analysed the information contained within the IMRs and having considered the chronology of events and the information provided by family members, the panel has reached the following conclusions:

Predictability and preventability

The review has not found any evidence to indicate that physical violence had ever been a major factor in SH and Adult B's relationship. There is one incident, outside the timeframe of the DHR where Adult B is alleged to have 'head-butted' his ex-wife HT during an argument a number of years previously but this could not be substantiated. No further evidence that he ever physically harmed SH prior to the incident could be identified.

There is one reference to an occasion when SH awoke to find Adult B standing over her with a pillow, but again the detail of this is not clear and cannot be substantiated.

Adult B's anxiety had been increasing to the point where his behaviour had become more unpredictable. SH made it clear in her telephone conversation with the Crisis Team on the evening of 16th August 2014 that she felt threatened and that she did not feel safe but this was not followed up. Her concerns had been expressed in the call to South Central Ambulance NHS Foundation Trust (SCAS) on 16th August 2014 and again to the Crisis Team worker, W4 during the assessment visit.

Adult B's previous behaviour could be described as controlling at times and as such it constituted domestic abuse. For example, he managed the finances of the household, but in the period leading up to the incident this took a more controlling form. Adult B withheld money from SH, is believed to have prevented her from leaving the flat in the week(s) preceding the incident and is thought to have withheld food and cigarettes from her. The withholding of food could have been particularly injurious given SH's diabetes. In fact, the controlling behaviour led to SCAS formally reporting safeguarding concerns for SH to West Berkshire Council although these concerns were not shared with the Crisis Team.

In reviewing the IMRs and supporting information, as well as the two independent Nurse and Psychiatrist reports, the panel have concluded that there were missed opportunities to identify and clarify the risk presented to SH. There was evidence of increasing risk towards SH from Adult B.

When weighing the information presented, the panel has come to the conclusion that despite the changing risk, in the context of Adult B's worsening anxiety and depression, the *potential* for physical harm towards SH could have been predicted and steps taken to reduce it. However, there was nothing in Adult B's presentation or behaviour in the period leading up to SH's death that indicated that Adult B was likely to kill her. On that basis, the panel concludes that her death was neither accurately predictable nor preventable.[1]

The evidence presented to the review

This review has been characterised by the strong consistency of evidence and information presented to it by the various agencies who had contact with SH and Adult B. The facts of the case are not in dispute by any organisation.

Understanding of SH's needs and the risks to her

SH's needs were lost within the volume of information received by the Crisis Resolution & Home Treatment Team (CRHTT) service and as a result were not afforded enough significance or priority in the CRHTT's thinking or responses.

Assumption combined with a lack of professional curiosity resulted in a paucity of actual knowledge about risk factors towards SH from Adult B. In addition, flawed assumptions about SH's intentions regarding where SH would spend the night following her visit to a restaurant with her sister on the evening of 16th August 2014 influenced the decision making about the degree of priority applied to her concerns by the CRHTT.

Adult B's presentation to healthcare professionals

When presenting to healthcare professionals, Adult B did not always disclose his circumstances to them and attempted to *"'hold it together'* by providing a more positive version than was actually the case. This lack of disclosure resulted in healthcare professionals not always being in possession of the full facts relating to his mental and physical health. This in turn had the potential to influence their responses to him.

There probably was a misdiagnosis of Adult B, and in the view of the independent psychiatrist, depressive disorder should have been identified earlier than it was. The independent psychiatrist considers that the diagnostic finding of the two forensic experts that Adult B had been suffering from

[1] The family agree with the Home Office letter, dated the 25the January 2018. The family firmly disagrees with the conclusion that the homicide was neither accurately predictable nor preventable.

psychotic depression at the time of the incident is more reliable than those of the CRHTT and the Mental Health Act assessors who saw him earlier.

Decision making by mental health professionals and their knowledge of domestic abuse

Some Berkshire Healthcare NHS Foundation Trust (BHT) staff made weak clinical judgments in relation to Adult B and there were areas where a lack of competency was demonstrated by staff in relation to their skills in the recognition of risk and suicidal ideation, knowledge of safeguarding and domestic abuse awareness and practices. The decision taken by W4 on the 16th August 2014 to discuss whether Adult B might physically harm SH in a conversation with both adults present was a serious error of judgment.

Furthermore, the knowledge of domestic abuse and domestic violence amongst healthcare professionals within primary and secondary care was variable in its depth and application. This highlights the gaps that exist in the embedding of knowledge, awareness and how to respond in relation to domestic abuse across the sector that must be addressed following this incident.

Organisational capacity within the mental health crisis team

The CHRTT was functioning beyond its capacity, that is to say that levels of demand for the service were high. Staff were functioning within a set of services that lacked clearly defined roles or filters to access. This resulted in staff treating a wide range of acuity, with presentations ranging from mild symptoms, relapsing patients and those with severe and enduring mental illness. Adult B appeared to get lost in this system.

Information sharing

There were deficits in the flow of risk information between SCAS and the CRHTT. In particular SCAS did not communicate their safeguarding concerns or the submission of the safeguarding form to West Berkshire Council. Had they done so the intervention of the CRHTT worker might have been different.

6. DHR Recommendations

1. We recommend that local mental health crisis services be strengthened, not only in terms of capacity to ensure swift response, but that they maintain evidence based methods for interview, assessment and response to mental health crisis. The matter of investment in these services will rest with local commissioners, but it is clear that these services must be responsive.

2. We recommend that updated information and advice be provided to GPs in the recognition and treatment of mental health needs. Furthermore we recommend that BHT put in place processes for regular updating of GPs about how and in what circumstances to refer to their services.[2]

3. We recommend that the requirement to conduct Carers Assessments be re-emphasised in both health and social care and that the outcomes of such assessments be appropriately shared between professionals and agencies.

4. We recommend that protocols for sharing risk/safeguarding information between SCAS and social services be reviewed and strengthened in light of the deficits highlighted in the DHR.

5. We recommend that GPs be advised to give consideration to services available through occupational health and employee assistance schemes provided by employers. This action would be assisted by the compilation of a list of employers in the county who provide occupational health and occupational health psychology services.

6. We recommend that health and social care professionals must wherever possible seek the views of an appropriate individual, for example spouse, carer, other relative and that this principle should be incorporated into health and social care professionals ongoing training and development.

[2] The DHR panel is aware that this programme of training for GPs has been implemented

7. We recommend that NHS England and the Home Office undertake work to examine the impact of the conflicting requirements of confidentiality and the Duty of Candour in the context of the conducting of Domestic Homicide Reviews and Mental Health Homicide Reviews. This case has demonstrated how these duties conflict and this places particular distress on families. The co-chairs will write to NHS England and the Home Office about this separately.

8. We recommend that the Home Office revise the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, to make clear the criteria that need to be met for a DHR Panel Chair to be considered fully independent.