West Berkshire District Council
Safer Communities Partnership

Domestic Homicide Review

Overview Report concerning the murder of Adult A who died in November 2017

Written by:

Steve Appleton
Managing Director
Contact Consulting (Oxford) Ltd

Independent Chair and author

Updated December 2020

CONTENTS

The DHR panel and chair would like to extend their condolences to the family and friends of Adult A. Conducting such a review highlights the impact of domestic abuse and of domestic homicide on families and friends. Its effects can be widespread and long lasting. It is the panel's hope that this DHR goes some way to providing answers for the family and informs learning to help in reducing the incidence of domestic abuse and domestic homicide.

Section One

1.1 Purpose of the Review

1. Domestic Homicide Reviews (DHRs) came into force on 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Adults Act (2004). The Act states that a DHR should be a review 'of the circumstances in which the of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by —

    - *a person to whom he or she was related or with whom he was or had been in an intimate personal relationship, or*

    - *a member of the same household as him or herself, held with a view to identifying the lessons to be learnt from the death'*

The purpose of a DHR 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 policies and procedures as appropriate; and

- Identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

2. In addition to agency involvement the review also examined the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. The review seeks to identify the lessons that may be learned from this case and through its recommendations, assist in making victims and those affected by domestic abuse safer in the future.

1.2 Subjects of the review

Adult A - deceased
White British female
Aged 30 at the time of her murder
Date of death: November 2017

Adult B - perpetrator
White British male
Aged 32 at the time of the murder

Child A

Child B

1.3 Process of the review

3. The decision to hold the DHR was taken in November 2017 having decided that the criteria set out within The Act was met. This decision was taken by the Community Safety Partnership under the chairmanship of the West Berkshire Council Chief Executive. The independent chair and author was appointed in September 2018. The delay in the commencement of the DHR was to allow the criminal justice process to be concluded.

4. The DHR has been conducted in line with the expectations of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2013. This guidance is issued as statutory guidance under section 9(3) of the Domestic Violence, Crime and Adults Act 2004. It has since been updated and was republished in December 2016. This review has used this revised guidance in the development of this Overview Report.

5. The review has considered agencies contact/involvement with Adult A and Adult B and their children from November 2015 to the date of the Adult A's murder in November 2017. The panel agreed upon this timescale of two years. The rationale for this was that this reflected the period in which the majority of contact with services had been undertaken and that the scoping revealed little contact of direct relevance to the review prior to that period.

6. The panel met in person on two occasions, though further discussions and exchanges took place electronically and by telephone conference.

7. The key purpose for undertaking these reviews is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

8. The review began in September 2018 and was completed in November 2019. This report was approved by the review panel and signed off by the West Berkshire Community Safety Partnership (Building Communities Together Partnership) prior to its submission to the Home Office. The report was updated in the light of feedback from the Pre-Quality Assurance Assessment feedback in August 2020.

1.4 Confidentiality

9. The review was conducted in private. All documents and information used to inform the review are confidential. The findings of the review should remain confidential until West Berkshire Community Safety Partnership (Building Communities Together Partnership) accepts the Overview Report, Executive Summary and Action Plan and it has been reviewed and approved by the Home Office Quality Assurance Panel.

1.5 Terms of Reference

The purpose of the DHR will be to:

- Establish what lessons can be learned from the domestic homicide regarding the way in which local professionals and organisations worked individually and together to safeguard the individuals who are the subjects of the review.

- 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 the lessons to service responses including changes to policies and procedures as appropriate.

- Contribute to the prevention of domestic violence and abuse homicide in the future, by using relevant findings to improve service responses for all subjects of domestic violence and abuse and their children through improved intra and inter-agency working.

10. The over-arching aim of this DHR is to increase safety for those who may experience potential and actual incidents of domestic abuse by learning lessons from the murder in order to change future practice. It will be conducted in an open and consultative fashion bearing in mind the need to retain confidentiality and not apportion blame. Agencies will seek to discover what they could do differently in the future and how they can work more effectively with other partners and take action to make necessary changes.

11. The Panel requested and reviewed Individual Management Reviews (IMRs) from each of the relevant agencies defined in Section 9 of the Domestic Violence, Crime and Victims Act (2004), and invited responses from any other relevant agencies or individuals identified through the process of the review

12. The Panel sought the involvement of the victim's family members to ensure that a robust analysis takes place of the full circumstances surrounding the incident under review.

13. The DHR will consider the intervention and contacts between agencies and the individuals who are the subjects of the review in the two year period prior to and including the date of the incident in November 2017.

Principles of the Review

14. The DHR will be undertaken in accordance with the current national DHR Guidance, most recently updated in December 2016. It will be guided by seven principles:

    - The DHR will be objective, independent & evidence-based
    - The DHR will be guided by humanity, compassion and empathy, with the subjects of the review at the heart of the process
    - The DHR will ask questions, identify issues and make recommendations that seek to reduce or prevent future harm, learn lessons
    - The DHR will not blame individuals or organisations, but if the evidence supports it, will seek to ensure that organisations are held to account for actions or the lack of.
    - The DHR will respect equality and diversity, giving due accord to the nine protected characteristics.

- The DHR will be conducted in an open and transparent way whilst safeguarding confidential information where possible
- The DHR will culminate in an Overview Report and Action Plan to effect change and disseminate lessons learned

Terms of Reference

1. Examine the events leading up to fatal incident, including the actions of relevant agencies.

2. Review the communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessment and management.

3. Examine how organisations adhered to their own local policies and procedures and ensure adherence to national good practice.

4. Review documentation and recording of key information, communication, case management and service delivery of all the agencies involved. Including, but not limited to, access to Police records, legal proceedings' documents and witness statements.

5. Produce a report that summarises the chronology of events, analyses and comments on the actions taken and makes any required recommendations

15. As stated in the principles of the review, and in Section 1.12 the DHR sought to respect equality and diversity, giving due accord to the nine protected characteristics.

1.6 Methodology

16. An initial scoping process was undertaken to establish the agencies and organisations that had contact with Adult A and Adult B. As part of this process a list of agencies and relevant contacts was developed and a timeline was created. This process enabled the gathering of information about types and level of contact and informed the decisions about which agencies and organisations to approach to request Individual Management Reviews.

17. Individual Management Reviews (IMRs) were requested from agencies to establish if there had been contact with and Adult A and Adult B and if so the nature of that contact and any services or interventions provided Adult A and Adult B.

18. The objective of the IMRs which form the basis for the review report was to provide as accurate as possible an account of what originally transpired in respect of the incident itself and the details of any contact and/or service provision by agencies with both Adult A and Adult B.

19. The IMRs were to review and evaluate this thoroughly, and if necessary to identify any improvements for future practice. The IMRs were also to assess the changes that have taken place in service provision during the timescale of the review and considered if changes are required to better meet the needs of individuals at risk of or experiencing domestic abuse.

20. The panel members reviewed the IMRs. These were presented and discussed at a panel meeting. Questions were asked and clarifications sought by the panel regarding specific elements of each of the IMRs. Some IMRs were amended and resubmitted as a result of those discussions.

21. A chronology was developed to aid the panel in its work. Although in some cases chronologies have, on Home Office advice, been shared as stand alone documents, following further advice on this point, the chronology is included within the Overview Report as an appendix.

22. The IMRs have been signed off by a responsible officer in each organisation and have been quality assured and approved by the review panel.

23. This Overview Report is based on IMRs commissioned from local agencies as well as summary reports and scoping information. These formed the basis of the information that was used to compile the Overview Report, alongside other information that was publicly available arising from the trial proceedings. The panel was mindful that the DHR is not a proxy for the criminal process and although the information arising from the trial informed the wider picture of the couple's life and home situation, it did not form part a central part of the panels deliberations. The report's conclusions represent the collective view of the review panel, which has the responsibility, through its representatives and their agencies, for fully implementing the recommendations that arise from the review.

1.7 Involvement with the family

24. The panel had wished to ensure that the wishes of the surviving family members informed the Terms of Reference.

25. Family members were provided with the Home office leaflet on DHRs and were provided with details of the support available from Action Against Fatal Domestic Abuse (AAFDA) so that they could access the services of that organisation should they wish to do so.

26. Contact was made with Adult A's mother via the social worker allocated to the children at the start of the review, but she did not respond. The Chair both wrote and attempted contact Adult A's by phone on more than one occasion. Following one of these contacts Adult A's mother did respond to the Chair saying that she did not wish to take part in the review process. The panel acknowledges that the lack of input from Adult A's mother represents a gap in the overview report, but efforts were made to engage.

27. Children and Family Services contacted other members of the family about the review on behalf of the panel but they declined to participate in the DHR process.

1.8 Involvement with the perpetrator

28. Contact was sought with the perpetrator by letter, and through contact with the Prison Service. He declined to participate in the review.

1.9 Contributors to the review

29. Agencies contributed to the review through the submission of IMRs and the provision of initial scoping information. Those agencies were:

- Primary Care through the Clinical Commissioning Group
- Sovereign Housing Association
- IRiS Drug and Alcohol Service
- Children's Primary School

1.10 Panel members

Steve Appleton	Managing Director Contact Consulting – Independent Chair
Susan Powell	Building Communities Together Team Manager, West Berkshire District Council
Chloe Bunting	Community Coordinator, West Berkshire District Council
Kathy Kelly	Designated Head of Safeguarding Adults, Clinical Commissioning Group
Adrian Brunskill	Regional Housing Manager, Sovereign Housing Association
Rachel Hasson	Borough Manager, IRiS Reading
Heidi Ilsley	Deputy Director of Nursing, Berkshire Healthcare NHS Foundation Trust
Rashida Baig	Principal Social Worker, West Berkshire District Council
Pete Campbell	Head of Children and Family Services, West Berkshire District Council
Lorna Skae	Service Manager, A2Dominion, West Berkshire Domestic Abuse Service

30. The panel members were independent and had no previous involvement with the subjects of the DHR.

1.11 The Overview Report author and DHR chair

31. The independent Chair of the panel and author of the DHR Overview Report is Steve Appleton. Steve trained as a social worker and specialised in mental health, working as an Approved Social Worker. During that time he worked with victims of domestic abuse as part of his social work practice. He has held operational and strategic development posts in local authorities and the NHS. Before working independently, he was a senior manager for an English Strategic Health Authority with particular responsibility for mental health, learning disability, substance misuse and offender health.

32. Steve is entirely independent and has had no previous involvement with the subjects of the DHR. He has considerable experience in health and social care and has worked with a wide range of NHS organisations, local authorities and third sector agencies. He is a managing director of his own limited company, a specialist health and social care consultancy.

33. Steve has led reviews into a number of high profile serious untoward incidents particularly in relation to mental health homicide and safeguarding of vulnerable adults. He has also led investigations into professional misconduct by staff and has chaired a Serious Case Review into an infant homicide. He has chaired and written over 25 DHRs for local authority

community safety partnerships across the country. He has completed the DHR Chair training modules and retains an up to date knowledge of current legislation.

34. Steve as independent and author has never been employed by any of the agencies concerned with this review and has no personal connection to any of the people involved in the case.

35. He has undertaken DHRs for this CSP previously.

1.12 Equality and Diversity

36. The panel has been mindful of the need to consider and reflect upon the impact, or not, of the cultural background of Adult A and Adult B and if this played any part in how services responded to their needs.

37. "The Equality Act 2010 brings together the nine protected characteristics of age, disability, gender reassignment (with a wider definition) marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation."[1] There are further considerations relating to income and pay gaps, the gender power gap in public sector leadership positions and politics, and the causes and consequences of violence against women and girls, under the Gender Equality Duty.[2]

38. The panel considered the nine protected characteristics in the Equality Act and three were found to have direct relevance to the review. These were sex and age. These characteristics were identified as relevant because they related directly to the circumstances of the victim and the perpetrator. The panel ensured that the review always considered these issues in their thinking about the engagement and involvement of organisations and professionals and where identified, the impact of them on decision making. Particular attention was paid to the nature of domestic abuse, which is most often perpetrated by men on women. In relation to age, research covering the period 2015-17 showed that that young women were more likely to have experienced partner abuse in the last 12 months than older women.[3] This

[1] Paragraph taken from Home Office Domestic Homicide Review Training; Information Sheet 14. P47
[2] Gender Equality Duty 2007. www.equalityhumanrights.com/.../1_overview_of_the_gender_duty
[3] Women most at risk of experiencing partner abuse in England and Wales: years ending March 2015 to 2017, Office for National Statistics

may suggest that as a younger woman Adult A was at higher risk than had she been older.

1.13 Dissemination

39. The Overview Report will be sent to all the organisations that contributed to the DHR. In addition an appropriately anonymised electronic version of the Overview Report will be posted on the West Berkshire Building Communities Together Partnership website. A copy will be provided to the Police and Crime Commissioner.

40. Members of the family will be contacted prior to publication to establish if they wish to receive copies of the report.

Section Two

2.1 Introduction and summary background

41. Adult A was a 30 year old married woman who lived with her husband, Adult B at their rented home in the western part of Reading. The couple had two young children, Child A and Child B.

42. They were described as childhood sweethearts, having met when they were teenagers. Adult B was two years older than Adult A. Adult A had a job working in a local pharmacy and Adult B worked repairing street lighting.

43. The couple moved to their rented housing association property in May 2017, having previously lived with the victim's mother in another part of Reading.

44. Adult A had a history of anxiety and Adult B had a lengthy history of drug misuse, principally cocaine. He had used the drug since the age of 19 but this was not known to his wife until very soon before she was killed.

45. It is believed that the couple had had a reasonable relationship and the school and GPs who had contact with them reported that they seemed a happy couple. However, it is believed that there were arguments between them, though there was no indication that these had ever been violent. These arguments have been described as low level bickering but nothing out of the ordinary.[4]

46. In the days leading up to her murder, Adult A and Adult B had had a period of sustained argument, including on the night of her murder, Adult A sending her husband a series of messages via mobile phone that related to her distrust of him and her concern about his drug use.

47. Some time on a night in November 2017, it is understood that the couple had an argument. At Adult B's trial it was alleged that Adult A had attempted to stab Adult B during that row. During the row Adult B attacked Adult A physically, punching her repeatedly and then strangling her. The injuries she sustained led to her death. A family member who visited the house found her body.

[4] Sentencing remarks of The Honorable Mr. Justice Julian Knowles

48. Adult B was convicted of manslaughter at Reading Crown Court in May 2018 and was sentenced to 11 years in prison. In his sentencing remarks the judge accepted that Adult A had attempted to stab Adult B and sentenced Adult B accordingly.

2.3 Overview of organisations involvement

2.3.1 The involvement of Primary Care

Adult A

49. Adult A was registered at a different GP practice to Adult B. Her children were registered at the same practice as their mother. She had been registered with the practice since 2010.

50. The IMR indicates a record of significant problems dating back to her childhood, but the detail of these has not been available to the reviewer. There are only records of face to face consultations with the GP dating back to 2010.

51. Adult A's first recorded appointment in January 2011 reports that she had been experiencing low mood for the two months previously. There is no record at this stage about her partner. A review of her mood was suggested by the GP but this does not appear to have taken place. Her next recorded appointment is six months later in June 2011 and relates to the removal of a contraceptive implant. Adult A attributed her low mood to this implant and it was removed in July 2011.

52. Adult A was not seen again until March 2013, when she reported being 'short tempered' but there was no low mood. She felt stressed according to the notes, but these do not record any further details about the antecedents of that stress.

53. In December 2013 Adult A was seen again by the GP and is described as experiencing anxiety, which she reported was getting progressively worse and that she was worrying about her children. There is some mention of a history of obsessive compulsive disorder, but this has not been mentioned anywhere in the notes previously. Again there is no mention of discussion about her partner or her relationship with him.

54. At review with the GP in February 2014 Adult A reported that her anxiety is now well controlled. She has been taking prescribed benzodiazepines.

55. Benzodiazepines act as a sedative, slowing down the body's functions, and are used for both sleeping problems and anxiety. They work by increasing the effect of a brain chemical called GABA (gamma amino butyric acid). GABA reduces brain activity in the areas of the brain responsible for:

    - rational thought
    - memory
    - emotions
    - essential functions, such as breathing

    The main effects of benzodiazepines are:

    - sedation
    - reduced anxiety
    - muscle relaxation

56. Benzodiazepines are very effective in the short term but they may stop working if taken continuously for more than a few months. This is because the brain adjusts to their effect, and may be hypersensitive to natural brain chemicals when they are stopped.[5]

57. The prescription of these is not the recommended NICE approved first line treatment for anxiety or depression. There is no record of any psychosocial review being undertaken.

58. In November 2014 Adult A again presented with symptoms of anxiety and feeling stressed. She requested a further benzodiazepine prescription. On this occasion the use of talking therapies was discussed but there is no record of the outcome of that conversation. She was prescribed Citalopram. Citalopram is a type of anti-depressant known as a selective serotonin reuptake inhibitor. It is often used in the treatment of depression, but also in cases of anxiety.[6]

[5] What are benzodiazepines? - Mind Guide https://www.mind.org.uk/information-support/drugs-and-treatments/sleeping-pills-and-minor-tranquillisers/about-benzodiazepines/
[6] NHS England information page https://www.nhs.uk/medicines/citalopram/

59. In September 2015 Adult A saw her GP about varicose veins, she said this was because she was due to get married. There is no record of any enquiry about her relationship although the records indicate her change in marital status in October that year.

60. There were routine appointments in August and November 2015 and January and April 2016. These related to cystitis. There is no record of any further discussions about anxiety and none about her relationship or her partner.

61. In 2016 there were only five consultations with the GP and all of these related to minor health problems that were not related to domestic abuse.

62. In 2017 there were two consultations between Adult A and her GP. One of which related to the road traffic accident she and her partner were involved in.

Adult B

63. Adult B was registered at a different practice to Adult A. He had been registered with the same GP practice since birth and the clinical records go back to 2001. These record frequent attendances over the years relating to asthma and chest issues, but nothing of note other than a fractured arm in 2006, which is believed to have been a work related injury.

64. There were two consultations in 2017, the first being in May 2017 following a road traffic accident. The next was in October 2017. The IMR indicates an issue with the record, which has a read code for depression. The summary suggests this is a significant past issue. The IMR author suggests that the system is pre-set to determine if a condition is significant or minor and how long it should remain active, or visible. A clinician can amend this, but it does not appear this was done.

65. During this October consultation, the physical symptoms are well recorded and the GP asked relevant questions about drug and alcohol use. Adult B reported that he had used cocaine (this had not previously been recorded as an issue) and alcohol (not recorded since 2008). He talked of enjoying his work, which he said was well paid, that he loved his children and there were no issues between him and Adult A and that they were happy.

66. He did also report that he had experienced suicidal ideation three weeks prior to the consultation, but that he did not have any intent to self-harm or to harm others. He told the GP he had been to the drug and alcohol service the day before and also to talking therapies. A PHQ9[7] assessment for depression and a GAD assessment[8] for anxiety were conducted. Anti-depressants were prescribed and he was provided with contact information for local crisis services and a plan for two week follow up.

67. The follow-up was done by at the start of November by phone. The note suggests Adult B had expected a face-to-face appointment, but he reported that his mood had improved and he would come in review. The incident took place three days later.

68. At interview with a criminal justice health practitioner, Adult B stated that Adult A had 'not been right' for about a year. He said that he had not been good enough for his wife, had experienced poor sleep and contemplated suicide by jumping in front of a train. He had ruminated on this for three months. He reported cocaine use over a number of years and was tearful when talking about his wife and children.

69. The clinician described Adult B as having good eye contact and being very conversant during interview, but also noted he did not seem sincere. He had scores of moderate anxiety and depression using the scales mentioned previously.

2.3.2 The involvement of Sovereign Housing Association

70. Adult A and Adult B took up their tenancy with Sovereign Housing Association (SHA) in mid May 2017. They had been nominated for housing by West Berkshire District Council. When nominated they had been living with Adult A's parents. They wished to move due a lack of space in the Adult A's mother's house.

[7] The PHQ-9 is a 9-question instrument given to patients in a primary care setting to screen for the presence and severity of depression.

[8] The Generalised Anxiety Disorder Assessment (GAD-7) is a seven-item instrument that is used to measure or assess the severity of generalised anxiety disorder (GAD). Each item asks the individual to rate the severity of his or her symptoms over the past two weeks.

71. A pre-tenancy assessment was conducted in April 2017 at Adult A's mother home. A section on the assessment relating to support being provided to the couple, indicated that there was none, and similarly the section about support that might be needed in future was also marked as being none. There was no history of anti-social behaviour or conduct. The budget section indicated the couple were both in employment.

72. A fixed term tenancy agreement was signed in mid-May 2017 and the couple both attended to sign it. One weeks' rent had been paid in advance as per the agreement. Future payments would be made by direct debit and there were no other queries or issues from the couple or from SHA.

73. At the end of May 2017 Adult A contacted SHA about issues with the property, stating it was not habitable. She was concerned about the condition of floorboards and holes the plaster. An Empty Homes Supervisor visited at the start of June 2017. A full gas central heating system had been installed and this had disturbed some of the floorboards. A repair order was raised and the property was deemed to be habitable. Adult A asked for a refund of two weeks rent, a one-week refund was granted. A week after the visit relating to repairs, a settling in visit/contact took place. This was not a face-to-face meeting but a phone call, to check how the family were settling in. The IMR records that a phone call is a standard means of contact when a household is considered as low risk, for example with no rent issues and no identified vulnerabilities.

74. At the start of October 2017 the couple were in rent arrears and a letter was sent to them by SHA. Adult A phoned SHA and said she believed Adult B had paid and was not aware of the arrears. She told SHA that she would look into the issue and phoned again later the same day to say a payment had been made. She requested a direct debit form and made a repayment agreement to clear the debt.

75. There was no further contact between this and the date of the incident.

2.3.3 The involvement of IRiS

76. IRiS is an adult drug and alcohol service based in Reading. It is operated by Cranstoun, a third sector organisation commissioned to provide drug and alcohol support and treatment services.

77. Adult B first had contact with IRiS in mid-October 2017 when he attended and completed his registration with the service. He presented as a self-referral via the open access service operated by IRiS. He reported that he had found out about the service by searching online. During the registration he reported that he was using cocaine three or four days a week and using around £400 a week on the drug. He said that he had first used cocaine aged 19 and had last used it four days before presenting to the service to register. He smoked tobacco, usually 20 cigarettes a day and consumed 10 units of alcohol between two and four times a month.

78. Adult B reported that he was married and had two children and that his wife was not a drug user. He had not accessed drug or alcohol treatment before and said he wanted to engage in a structured programme to stop using cocaine.

79. He said he was in full employment, and thus requested late appointments. Adult B did report that he was not taking medication prescribed by his GP for his mental health and that he had had suicidal thoughts in the week before attending IRiS after a heavy session of cocaine and alcohol use. He was provided with a crisis telephone number.

80. A week later the service contacted him by telephone to offer him a full assessment and this proposed appointment was accepted and was scheduled to take place a week later. A text message was sent to Adult B to confirm this.

81. On the day of the scheduled assessment appointment, Adult B contacted IRiS by telephone to cancel the appointment as he could not finish work in time to make it. It was rebooked for a week later.

82. On the day of the rescheduled appointment a text message was sent to Adult B, which was standard practice to remind the client of the appointment. No response was received and Adult B did not attend the assessment appointment.

83. The following day IRiS attempted phone contact with Adult B and there was no response. There was no record of whether the worker left a message. The incident then occurred and IRiS closed the case as Adult B had been remanded in custody.

The involvement of the Children's Primary School

84. The children of the couple attended primary school. Their daughter, Child A was the eldest of the two, aged 10 and her brother Child B was seven at the time of the incident.

85. Child A was admitted to the school register in September 2012 following an admission enquiry visit in October 2011. The school had been advised that Child A's grandmother would be helping with pick-ups at the end of the school day.

86. Child B was admitted to school register in 2014 following a pre-registration meeting. There is no record of which parent attended that meeting.

87. In September and November 2012 and February and June 2013, Adult A made holiday requests for Child A. These were instances of requesting for Child A to be absent from school during term time. The absences were all authorised by the school and related to Child A having a holiday, to attend a cousins 30th birthday party and for a day trip with her grandmother.

88. A further holiday request was made in September 2013 in advance of a holiday later in the year and again in January 2014 for Child A to attend an uncle's birthday party. Again these requests were authorised as was a request in July 2014. This pattern of requests continued in November 2014, March 2015, November 2015, April 2016, November 2016 and September 2017. The requests from November 2014 were made in respect of both Child A and Child B.

89. In total Child A had 31 days approved absence between 2012 and 2017. Child B had 15 days approved absence between 2014 and 2017.

90. The IMR shows Child A to have been a sociable child at school, there were no concerns about her, she seemed happy and was making good progress. Child B was similarly reported to be settled and friendly with other children, but his parents who both attended a parents evening in the first year of his attendance were concerned he could be easily lead.

91. By 2015 the situation had not changed, and both children were reported to be happy, had good relationships with other children and behaved well. This continued in 2016, both were making good progress at school and were hard working.

92. The last parents evening recorded in February 2017 indicates that Child A had good friendships, was supportive of her peers, had a good attitude to learning but needed to believe in herself a bit more.

93. The last contact between Adult A and the school was in October 2017 when she joined other parents in school to participate in school project with the children. This was approximately three weeks before the incident.

2.4 Analysis of IMRs

Primary Care – Adult A

94. Adult A had a history of regular contact and consultations with her GP. These related to issues of anxiety and depression. There is no indication that issues of domestic abuse or violence were evident during those consultations, indeed there is little to suggest that issues relating to Adult A's relationship was ever explored during her GP consultations.

95. The GPs had undertaken the relevant training on domestic abuse that has been provided to practices across the local area. It is not clear whether or not questions were asked. Certainly they should have been, particularly as the IMR states, women who experience domestic abuse or violence are found to have higher rates of GP attendance with gynae issues, abdominal pain and mental health issues.[9]

96. It may be that these issues were discussed in passing, but were certainly not recorded. It appears that more general questions about 'how everything is' were asked but is this specific enough to expect any detailed response or enable to patient to respond directly on particular issues.

97. However, there is no evidence that the overall range of contact by the GPs was anything other than of the expected standard. The only issue of note was the prescribing of benzodiazepines for anxiety. Benzodiazepines are not the NICE recommended first line treatment.

98. Evidence-based psychological interventions are effective treatments for anxiety disorders and should be offered as first-line treatments in preference to pharmacological treatment. They include both low-intensity interventions

[9] Domestic Violence and Health Care: What Every Professional Needs To Know: Schornstein SL, 1997, Physical and mental health effects of intimate partner violence for men and women Coker A et al, 2002 Medical care utilization patterns in women with diagnosed domestic violence Ulrich et al, 2003

incorporating self-help approaches and high-intensity psychological therapies. Using the stepped care model allows the least intensive intervention that is appropriate for a person to be provided first, and people can step up or down the pathway according to changing needs and in response to treatment.

99. People with anxiety disorders should not be prescribed benzodiazepines or antipsychotics unless there are specific clinical reasons why these treatments may be of short-term benefit (for example, in anxiety disorder crisis).[10]

100. Although the treatment offered was not first line, it does appear to have had some beneficial effect. Talking therapy was discussed but Adult A did not wish to take up this form of intervention.

Primary Care - Adult B

101. There is nothing to indicate that Adult B was engaged in any form of domestic abuse, but there is also nothing to suggest that this was enquired about by the GPs. The GPs commented that Adult B presented as a family oriented man who wanted to change.

102. Adult B appeared to be open to engaging in seeking help and there was nothing in his presentation to the GP that raised any concerns in relation to safeguarding. The GP had concluded that there was no risk to Adult B, or anyone else, including Adult A as a result of his drug use. The disclosure of drug misuse came very soon before the incident and did not allow the GP the opportunity to explore this further with him.

103. No external communication took place as the GP was aware that Adult B had already made contact with the local IRiS team.

104. In the cases of both Adult A and Adult B, there appear to have been good and positive relationships between them and their respective GPs. Record keeping of consultations was, overall, of a high standard.

[10] NICE quality standard to improve recognition, assessment and availability of treatments for anxiety disorders https://www.nice.org.uk/guidance/qs53/documents/new-nice-quality-standard-aims-to-improve-recognition-assessment-and-availability-of-treatments-for-anxiety-disorders

105. The presentation of the couple to their respective GPs was one where it appeared they were residing together but neither GP surgery had a clear view of the nature of their relationship or their circumstances beyond their health conditions.

106. There is no evidence of any professional practice concerns, however, there remains an ongoing gap in the routine enquiry in relation to domestic abuse.

107. The IMR makes one recommendation – detailed in later in the report.

Sovereign Housing Association (SHA)

108. There appears to be nothing remarkable about the engagement between Adult A and SHA. The pre-tenancy process was appropriately completed. It is worth noting that Adult B was not present during the pre-tenancy assessment nor at the viewing of the prospective property. SHA usually prefer both parties to be present but there is nothing unusual in one or other not being present, often due to work commitments.

109. On the other hand, the fact that Adult A was on her own during this process would have afforded her with the opportunity to raise any concerns about the process or her circumstances, however she did not do so.

110. It does appear that although Adult A and the children were resident with her mother prior to moving to the SHA property, Adult B may at times have lived separately at his parent's address. It has not been possible to clarify this point.

111. The fact that by moving into the SHA property represented the first time Adult A and Adult B, along with their children, would have lived together as a family on their own may be important contextually.

112. There is nothing to indicate that SHA staff did anything other than follow the appropriate processes and policies in relation to assessing and awarding the tenancy.

113. The IMR does not make any recommendations.

IRiS

114. Adult B referred himself to IRiS and initially it appeared that he was self-motivated and wished to address his misuse of drugs.

115. The IRiS service appropriately registered him with their service and took a history. They were aware that Adult B was married and had children and that he was fully employed. It is not clear if any direct questions were asked about the nature of his relationship with Adult A, however he did tell them that his wife was not a drug user. It does not appear that any enquiry was made of Adult B about any issues about his relationship with Adult A, including domestic abuse.

116. The worker who completed the registration did note risks relating to Adult B, specifically of his potentially driving having used drugs or alcohol, that he was not taking the medication prescribed by his GP for his mental health issues and that he had had suicidal thoughts.

117. Although these risks were appropriately identified and recorded, these do not seem to have been more widely communicated to Adult B's GP. Indeed the protocols for advising a GP of a self-referral or the findings of registration meetings and assessments is not clear.

118. A comprehensive assessment was booked but Adult B did not attend the first appointment due to not being able to leave work. Although another appointment was arranged and agreed, when contacted the day before and on the day, he did not respond and did not attend the assessment appointment.

119. Having followed up again, the case was subsequently closed following Adult B's arrest and detention in custody following the incident.

120. The main gap identified in practice was that the IRiS team did not have detailed contact and did not share information with colleagues in Children's Services. This meant that neither were able to share details of their contacts or any concerns or issues.

121. IRiS had limited contact with Adult B but throughout that contact the staff involved correctly followed IRiS policy and process in relation to registration, attempted to offer appointments that would fit around Adult B's work schedule and did follow up non-attendance in accordance with good practice within the service.

122. There has been a growing realisation that problem drug use and problem drug users can have a deep and enduring effect on a wide range of relationships. For example it is known that children of drug-dependent parents are likely to be the subject of child protection proceedings.[11]

123. The relationship between substance use and domestic abuse is not straightforward.

124. Evidence for the relationship between domestic abuse and drug and alcohol intoxication is plentiful in crime surveys but tends to focus, peculiarly, on the behaviour of victims more often than offenders.

125. A 'Crime in England and Wales' (formerly the British Crime Survey) self-completion questionnaire for 2010-11, which included a special focus on the nature of partner abuse, found that 21% of those who had experienced partner abuse in the last year thought the perpetrator was under the influence of alcohol while eight per cent thought they were under the influence of illicit drugs. The Mayor of London's 2005 report found that 93% of domestic violence perpetrators surveyed with substance misuse problems reported that they were problematic substance users before they became domestically violent.

126. In half of the cases, problematic substance use increased during incidents of violence. Most perpetrators interviewed believed that substance use was an excuse, not a cause of violence.[12]

127. A 2014 study published by the American Society of Addiction Medicine indicates that 40-60% of domestic violence issues are linked to substance abuse.[13] Also, in that study, more than 1 in 5 male perpetrators admitted that

[11] Street, K., Whitlingum, G., Gibson, P., Cairns, P. and Ellis, M. (2008) 'Is adequate parenting compatible with maternal drug use? A 5-year follow-up', *Child: Care, Health & Development*, 34(2), 204–6

[12] Making the connection: Developing integrated approaches to domestic violence and substance misuse Drug Scope 2013

[13] https://www.asam.org/resources/publications/magazine/read/article/2014/10/06/intimate-partner-violence-and-co-occurring-substance-abuse-addiction

they had consumed substances before they performed acts of violence. That is a clear indication showing that taking alcohol or drugs can worsen the risk of engaging in abusive behaviours.

128. Cocaine is the second most abused drug in the world after cannabis. Cocaine stimulates the central nervous system and leads to intense euphoria coupled with the sensation of strength and intellectual prowess. At the same time, it suppresses the appetite, fatigue and pain, while also reducing inhibitions. But, once these effects have worn off, users become anxious, agitated and feel the need for more of the drug.

129. As a consequence of these effects, many cocaine users are prone to violence. Significantly, those who inhale crack cocaine tend to become more angry and violent than those who snort crystalline cocaine. Researchers believe that the rage and violent behaviour associated with cocaine use could be result of the drug's effect on neurotransmitters in the pleasure centres of the brain. It is also thought that cocaine causes changes in the levels of norepinephrine and serotonin that might lead to aggressive behaviour, hyperactivity, impaired judgement and paranoia.

130. It is perhaps helpful to state that although substance misuse can raise the risk of violence, it should not be inferred that this should be seen as a mitigation in respect of the perpetration of domestic abuse.

Children's Primary School

131. The school had contact with Adult A throughout the period in which the two children were pupils. The processes for pre-registration were followed and both children were admitted to the school roll.

132. There is nothing remarkable in the account of the children's attendance at school. They both appear to have been happy children who settled well in school and were doing well.

133. The contact between the school and Adult A was typical of that between parents and the school and there was nothing in that contact that would have led to any concerns in relation to the children.

134. There were a number of authorised requests for absence during term time over the period between 2012 and 2017. All of these were made by Adult A and were approved. The majority were for holidays or to attend family

functions. Whether the number of requests was unusually high or not is hard to judge as there is nothing to benchmark these against. Whether the school made any further inquiry about these requests is not clear.

135. The school does have a safeguarding policy in place and all staff are appropriately trained.

136. The IMR makes one recommendation – detailed later in the Report.

2.4 Analysis of other potential factors

137. The panel acknowledged that there might have been other factors that influenced the couple's relationship.

138. Adult A experienced mental health problems, most notably anxiety, though there was no other defined clinical diagnosis. Although the panel could not find evidence to suggest that her mental health was a direct factor, it is known that there is a strong association between having mental health problems and being a victim of domestic abuse.[14] There are higher rates of domestic abuse amongst people who have mental health problems compared to those who don't.[15] For some victims, like Adult A, their mental health problems preceded experiences of domestic abuse. In some cases the abuse may intensify them, though there was no evidence of this in Adult A's case.[16]

139. The panel recognised that domestic abuse and poor mental health are both stigmatised issues, making it particularly difficult for those affected by both to speak out about their experiences. The panel notes that all organisations have a role in improving understanding and responses to these strongly interrelated issues across the whole of society.

140. The part that Adverse Childhood Experiences can play in a person's later life has gained greater recognition and prominence. Adverse Childhood Experiences are stressful events occurring in childhood. The term was originally developed in the USA for the Adverse Childhood Experiences survey, which found that as the number of Adverse Childhood Experiences increased in the population studied, so did the risk of experiencing a range of health conditions in adulthood.

[14] Safe and well: Mental health and domestic abuse, Spotlight Report May 2019
[15] Trevillion, K., Oram, S., Feder, G., & Howard, L.M. (2012). Experiences of domestic violence and mental disorders: a systematic review and meta-analysis. PloS one; 7(12): e51740. DOI: 10.1371/journal. pone.0051740
[16] Humphreys, C., & Thiara, R. (2003). Mental health and domestic violence: "I call it symptoms of abuse." The British Journal of Social Work, 33 (2): 209–226. https://DOI.org/10.1093/ bjsw/33.2.209

141. There have been numerous other studies that have reached similar findings including in Wales and England.[17] Although there was no evidence that ACEs were a factor in this case, the panel did consider if they played any part.

3.0 Conclusions

142. This section sets out the conclusions of the DHR panel, having analysed and considered the information contained in the IMRs within the framework of the Terms of Reference for the review. The Chair of the DHR is satisfied that the review has:

- Been conducted according to best practice, with effective analysis and conclusions of the information related to the case.
- Established what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support vulnerable people and victims of domestic violence.
- Identified 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.
- Reached conclusions that will inform recommendations that will enable the application of these lessons to service responses including changes to policies and procedures as appropriate; and
- Will assist in preventing domestic violence homicide and improve service responses for all vulnerable people and domestic violence victims through improved intra and inter-agency working.

143. The conclusions presented in this section are based on the evidence and information contained in the IMRs and the discussions between panel members. It draws them together to present an overall set of conclusions about the case. It is important to note that the conclusions of the review are set in the context of any internal and external factors that were impacting on delivery of services and professional practice during the period covered by the review.

[17] Adverse Childhood Experiences International Questionnaire. WHO
https://www.who.int/violence_injury_prevention/violence/activities/adverse_childhood_experiences/en/

3.1 Conclusions of the DHR panel

144. Having reviewed and analysed the information contained within the IMRs and having considered the chronology of events and the information provided the panel has drawn the following conclusions:

- Adult A and Adult B had been in a long-term relationship and had known each other since they were teenagers. They married in 2015.

- Their relationship appears to have been, at least for a period, a good one. It was on occasion prone to disagreements and what was described as low level bickering. This appeared to escalate in the months preceding Adult A's murder.

- The couple lived with Adult A's mother for a significant period. It is not entirely clear if Adult B always resided at Adult A's mother's house or spent more time with his own parents.

- When the couple moved to their housing association property it represented the first time that they lived together as a family in their own home, without other members of the extended family.

- It is known from the court hearing that there were a number of instances of arguments, none known to be physical, and it may have been that any problems in their relationship were exacerbated by not being constrained by living in Adult A's mother's home.

- There was very limited contact with statutory agencies. The main contact for both Adult A and Adult B was with their respective GP practices.

- In Adult A's case anxiety was a factor and the GPs did provide treatment. This was in the form of benzodiazepine prescriptions. This is not the recommended first line treatment for anxiety. There is evidence that talking therapy was offered but Adult A did not want to pursue this. Whether other forms of poly-pharmacy could have been offered would be a clinical decision but there is no evidence that anything else was considered.

- Adult B had a history of drug misuse. His use of cocaine escalated in the months before the incident, although it is not clear why. His habit was costing around £400 per week, which would have had an impact on his finances,

despite him having a well-paid job. This may have been in part a cause for the rent arrears that were experienced.

- Adult B's use of cocaine undoubtedly led to changes in his behaviour and adversely affected his relationship with Adult A. Its contribution to the fatal incident is not clear and was not mentioned as an aggravating factor in the Judge's summing up and sentencing remarks. Nonetheless, the detrimental impact it had on their relationship is clear.

- Adult B did seek help through IRiS, via a self-referral but did not take up the assessment appointment he was offered, despite it being rescheduled.

- During the initial IRiS registration interview with Adult B, it does not appear that any enquiry was made of Adult B about any issues about his relationship with Adult A including those relating to domestic abuse.

- It does not appear that IRiS made any contact with the GP practice to advise of their contact with Adult B. There was also a gap in contact between IRiS and Children's Services.

- The fact that Adult A and Adult B were registered with different GP practices meant that there was no cross-practice information about either of them. This is not unusual and indeed there was not anything that meant there would have been any direct contact between the practices.

- It appears that neither set of GPs had any detailed knowledge of Adult A and Adult B's relationship. Again this may not be unusual given they were seen by different practices.

- It does not appear that routine enquiry was used by the GPs to ascertain whether there were any relationship issues or instances of domestic abuse, with either Adult A or Adult B. This must be put into the context of there being nothing presented to them that might have raised concerns and prompting them to be more specific in their questioning.

- In the period leading up to the incident there had been a deterioration in the couple's relationship. It does appear that Adult B's cocaine use was at the centre of this, given that Adult A had only recently become aware of it and it was impacting on Adult B's behaviour. Adult A had sent a series of text messages to Adult B telling him she wanted to stab him, this happening in May and July 2017.

- The sentencing remarks of the Judge at the trial of Adult B suggest that on the night of the incident the couple had rowed and exchanged a number of abusive messages, most of these directed to Adult B by Adult A. They had had sexual intercourse that night, but afterwards Adult B was unable to sleep and then Adult A sent him a number of messages saying she did not trust him.

- The relationship between the couple appears at times to have been difficult and arguments were not uncommon. Although Adult A had made threats towards Adult B these had never been followed through.

- There was no evidence that there was any risk in the relationship that was known about by those agencies that had contact with the couple.

- The nature of Adult B's drug misuse was not regarded as a significant risk factor other than to his own health and wellbeing.

- Although Adult B had felt low in mood and expressed some suicidal ideation, there was no evidence that he presented with a mental illness.

- Adult B would not have met the threshold for secondary care mental health services. Although he did not take the anti-depressant that had been prescribed it does not appear that this had any bearing on the outcome. More likely his drug use was the key catalyst.

145. The panel's overriding conclusion is that despite there being no direct evidence presented to agencies of issues relating to domestic abuse or relationship difficulties, and thus the lack of routine enquiry, it is clear that there could have been a heightened degree of professional curiosity that might have drawn out information that could have provided a more holistic view of the couple's relationship.

146. In many respects this case was an example where the circumstances of the couple were not known more broadly to public service organisations. Given that it has not been possible to speak with family members it is unclear to what extent they were aware of any domestic abuse, or indeed of the other issues within the relationship. Whether greater awareness of the issues surrounding domestic abuse in communities would have made any difference in this case is therefore hard to judge.

4. Lessons learnt

147. This case has highlighted three key learning points. These are summarised below:

148. Where individuals are not in regular or sustained contact with public services, instances of domestic abuse can remain hidden and unknown. This can have the effect of those agencies that could provide support being unable to provide help and advice. At the same time this leads to a key lesson for both organisations and communities, namely, that the issue of domestic abuse requires greater awareness and that societal responses need to change so that victims who are not in contact with services feel better able to both recognise the abuse to which they are subjected, but also to talk about it and report it.

149. The nature of professional curiosity, or lack of it, remains an issue where more work needs to be done and this applies not only in the geographical area where this fatal incident occurred, but across the country. It demonstrates that further work is needed to embed the concept of routine enquiry in the daily practice of professionals, not only in health and social care agencies, but in others public and third sector organisations.

150. There is a dearth of research in relation to the connection between drug use and domestic abuse. The learning to be taken from this case is that this relationship requires further research that can improve the understanding of professionals working in the field.

5. Recommendations

This section of the Overview Report sets out the recommendations of the DHR panel.

5.1 DHR Recommendations

Many of the issues raised in the IMRs that have been analysed and commented upon in the Overview Report are subject to recommendations within those IMRs. Given the conclusions of the panel, we make the two recommendations.

1. GP practices should be reminded of the necessity to make routine enquiry about domestic abuse. West Berkshire has implemented a wide-ranging programme of GP training but this case demonstrates there is more to do to embed routine enquiry in day-to-day practice.

2. The Drug and Alcohol Service should put in place a process for ensuring that GPs are advised when a patient presents to their service. The issues of confidentiality notwithstanding, a policy or process for when this should take place will better guide staff on when this should occur. This should apply to the services provided by the organisation not only in West Berkshire but in it other locations.

5.2 IMR Recommendations

Clinical Commissioning Group

Clinical Commissioning Group to continue to promote domestic abuse training in primary care based on sign indicators presentation of stress anxiety and clinical research and effective record keeping.

Children's Primary School

The school will complete the Domestic Abuse and Domestic Abuse Champions training being offered by Building Communities Together Partnership.

*during the period of this review IRiS ceased to be the Drug and Alcohol Service Provider in Reading and the Recommendation is directed to the incoming Service Provider and also to IRiS in their practice in other localities.