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 Adult A in Berkshire in November 2017. The DHR was commissioned by the Community Safety Partnership of West Berkshire District Council.

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, a 10 year old and Child B, a 7 year old. Adult A had a job working in a local pharmacy and Adult B worked repairing street lighting.

The couple moved to their rented housing association property in May 2017, having previously lived with her mother in another part of Berkshire.

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 her death.

In the days leading up to her death, Adult A and Adult B had had a period of sustained argument, including on the night of her death, 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.

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.

Adult B was convicted of manslaughter at Reading Crown Court in May 2018 and was sentenced to 11 years in prison

The report and this Executive Summary uses Adult A to denote the victim in this case. It was taken to maintain confidentiality and in the absence of agreed pseudonym with the family.

2. The DHR process

A DHR was recommended and commissioned by the Community Safety Partnership in December 2017 in line with the expectations of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2016. This guidance is issued as statutory guidance under section 9(3) of the Domestic Violence, Crime and Adults Act 2004.

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.

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

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

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

3. Views of the family

The panel had wished to ensure that the wishes of the surviving family members have informed the Terms of Reference and are reflected in the report.

Contact was made with Adult A's mother via the social worker allocated the children at the start of the review, but she did not respond. The Chair has both written and contacted by phone. 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.

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.

4. Involvement with the perpetrator

Contact was sought with the perpetrator by letter, and through contact with the Prison Service. He declined to participate in 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, the panel has reached 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 death.

- 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 case for the rent arrears that were experienced.

- 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.

- 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 that 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 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.

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.

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.

6. Lessons learnt

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

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.

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.

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.

7. 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. IRiS should put in place a process for ensuring that GPs are advised when a patient presents to their service. The issues of confidentiality not withstanding, a policy or process for when this should take place will better guide staff on when this should occur.