



DOMESTIC HOMICIDE REVIEW
&
SERIOUS CASE REVIEW

Elmbridge Community Safety Partnership
&
Surrey Safeguarding Children Board

Adult S and Child CC
OVERVIEW REPORT

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1. INTRODUCTION

1.1 Details of the incident

- 1.1.1 On 24 June 2015 a business associate of Adult S, contacted Surrey Police concerned for Adult S's welfare as she had not seen her since 18 June 2015. She informed the call taker that Adult S had a 14-year-old daughter, Child CC. She stated that she had contacted a number of other companies that Adult S worked with but no-one had heard from her. Police advised her to visit the family home at the weekend to see if they had returned home or to speak to neighbours.
- 1.1.2 At 08:34 on 29 June 2015 a friend of Adult R, contacted Surrey Police from his home in France. He explained that Adult R had taken his own life in France and that he was concerned for Adult S and Child CC as Adult R had indicated that he had killed them both and had left them deceased at home in Surrey.
- 1.1.3 At 09:37 on 29 June 2015 Surrey Police attended the family's home address and discovered the bodies of Adult S and Child CC.
- 1.1.4 On 23 November 2015 HM Coroner for Surrey returned verdicts of unlawful killing in respect of Adult S and Child CC. The cause of Adult S's death was strangulation and the cause of Child CC's death was suffocation.
- 1.1.5 The panel would like to express its sincere condolences to the family of Adult S and Child CC for their losses.

1.2 The review

- 1.2.1 Surrey Police notified the local Community Safety Partnership on 2nd July 2015 that the case should be considered as a DHR. The local Community Safety Partnership decided to conduct a DHR on 9th July 2015, notified the Home Office on 13th July 2015 and commissioned Standing Together against Domestic Violence to provide a chair and report writer for this process.
- 1.2.2 This Domestic Homicide Review (DHR) was commissioned by the local Community Safety Partnership in accordance with the Revised Statutory Guidance for the conduct of Domestic Homicide Reviews published by the Home Office in March 2013.
- 1.2.3 The Strategic Case Review Group (SCRG) of the Surrey Safeguarding Children Board (SSCB) received a referral for Serious Case Review (SCR) and considered the case on 27 July 2015. Additional information was requested from agencies

and the case was considered again on 30 September 2015. The group agreed that the case meets the criteria for a proportionate SCR, in accordance with the Working Together 2015 statutory guidance. The Independent Chair agreed a joined DHR/SCR process for this case. The Office for Standards in Education, Children's Services and Skills (Ofsted), Department for Education (DfE) and the SCR National Panel were notified on 29 October 2015.

1.2.4 Surrey Police notified the local Community Safety Partnership on 2nd July 2015 that the case should be considered as a DHR. The local Community Safety Partnership decided to conduct a DHR on 9th July 2015, notified the Home Office on 13th July 2015 and commissioned Standing Together against Domestic Violence to provide a chair and report writer for this process.

1.2.5 The purpose of this review is to:

- 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 those lessons to service responses including changes to policies and procedures as appropriate.
- d. Prevent domestic homicides and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.
- e. Meet the requirements for Serious Case review with regard to Child CC and specifically to:
 - Establish 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 promote the welfare of children;
 - 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; and

- Improve intra- and inter-agency working and better safeguard and promote the welfare of children.
- 1.2.6 The review process does not take the place of the criminal or coroners' court nor does it take the form of any disciplinary process within any of the agencies involved.
- 1.2.7 Due to complexities with the availability of the Chair and Panel members, the first panel meeting was held on 01 October 2015. A subsequent meeting was held on 15 December 2015 where the independent management reviews (IMRs) and other information was considered. The draft report was reviewed at a meeting on 10 May 2016 with a final meeting of the panel on the 27 June 2016. The SCRG also considered the draft report on 27 May 2016 and the final report on 27 July 2016.
- 1.2.8 Once published, the final report will be shared with the governance boards and committees of participating statutory and voluntary agencies. Prior to publication, the report will be shared with DfE, OFSTED and SCR National Panel as per SCR process. The report will also be published on the SSCB website.

1.3 Terms of Reference

- 1.3.1 The full terms of reference are included in Appendix 2.
- 1.3.2 The review looked at the involvement of statutory and voluntary agencies with Adult S, Adult R and Child CC during the period of 01 June 2010 to 29 June 2015. Agencies were asked to summarise their involvement before 01 June 2015.
- 1.3.3 IMRs were completed by the Independent Secondary School and Surrey Police as they were the only agencies to have substantial involvement with either Adult S or Child CC.

1.4 Parallel and related processes

- 1.4.1 **Inquest.** On 23 November 2015 HM Coroner for Surrey returned verdicts of unlawful killing in respect of Adult S and Child CC. The cause of Adult S's death was strangulation and the cause of Child CC's death was suffocation.

- 1.4.2 **Criminal prosecution.** As Adult R took his own life there is no opportunity to prosecute him for any offence. The investigation by Surrey Police into the death of Adult S and Child CC resulted in a clear conclusion that Adult R was the perpetrator of both killings.
- 1.4.3 **Serious Case Review.** The Surrey Safeguarding Children Board were represented on the DHR panel from the outset. As Child CC was 14 at the time of her death the issue of a serious case review (SCR) was considered at length. As the circumstances of Child CC's death relate directly to those of Adult S it was felt that this report should include any issues in relation to the death of Child CC as a joint SCR process. Every attempt has been made to include the voice of Child CC within this process and discover any relevant learning. It was therefore agreed by the Panel that the Terms of Reference for this review would include both Adult S and Child CC.

1.5 Panel membership

- 1.5.1 The panel consisted of representatives from the following agencies:
- a. Independent Secondary School
 - b. Surrey Police
 - c. Surrey Safeguarding Children's Board
 - d. Local Community Safety Partnership
 - e. Local CCG
 - f. Local GP Surgery
 - g. Local Citizens Advice Bureau / Local Domestic Abuse Outreach Service
 - h. Surrey Safeguarding Adults
 - i. Standing Together Against Domestic Violence

1.6 Independence

- 1.6.1 The Chair of the Review was Anthony Wills, an associate of Standing Together against Domestic Violence which is an organisation dedicated to developing and delivering a Coordinated Community Response to domestic abuse through multi-

agency partnerships. Anthony has conducted domestic abuse partnership reviews for the Home Office as part of the Standing Together team that created the Home Office guidance on domestic violence partnerships, '*In Search of Excellence*' (Wills et al, 2013). He was also Chief Executive of Standing Together from 2006 to 2013. He has undertaken the Home Office accredited training for DHR Chairs and also worked as a police officer for 30 years, concluding his service as a Chief Superintendent. He has no connection with the local Community Safety Partnership or the agencies involved in this review.

- 1.6.2 The Overview Report Writer was Jessica Donnellan, the Senior Projects Coordinator at Standing Together against Domestic Violence. Jessica has over ten years' experience working in the domestic violence and abuse sector. Jessica has no connection with the local Borough or any of the agencies involved in this case.

1.7 Methodology

- 1.7.1 Following an initial scoping exercise by the local Borough Council and their partners it was established that very limited contact had taken place with Adult S and/or Child CC. The review sought information from these agencies and most were represented on the panel.
- 1.7.2 IMRs were provided by:
- a. Surrey Police
 - b. Independent Secondary School
- 1.7.3 Additional information sought and reviewed by the panel included patient records from:
- a. Local GP Surgery
 - b. Private Hospital
- 1.7.4 The Chairs would like to thank all those who contributed their time, cooperation and patience to this review.

1.8 Contact with family and friends

- 1.8.1 The Chair sought contact with Adult S and Child CC's families through the Surrey Police Family Liaison Officer (FLO). Contact with Adult R's family was sought via the Investigating Officer in the case.
- 1.8.2 All close relatives were contacted by the FLO and written to separately by Standing Together. One relative initially accepted the offer of a meeting to discuss the review but then cancelled that meeting. Subsequent attempts to arrange a new date have not been successful.
- 1.8.3 A work colleague of Adult S was contacted but declined to participate. The personal assistant for the family did agree to meet with the DHR Chair and overview report writer and provided some useful background information.
- 1.8.4 The panel considered speaking to Child CC's close friends from school. They had provided extensive and detailed statements to the police which were very helpful in establishing some understanding of Child CC's character. The panel decided, after some debate, that a further meeting with them would be unnecessary as they had been so informative and they would have been repeating what had clearly been a painful process.

1.9 Equalities

- 1.9.1 Adult S was a 47-year-old heterosexual white British woman. Her relationship with Adult R began whilst they were at school and they married in Barbados in 1999, although the marriage was not registered in the UK.
- 1.9.2 Child CC was a 14-year-old white British young woman.
- 1.9.3 The nine protected characteristics of the Equality Act 2010 (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation) were considered and with the possible exception of sex and marriage are not considered relevant. The characteristics of sex and marriage are considered further below.

2. The Facts

2.1 The killings of Adult S & Child CC

- 2.1.1 On 17 June 2015, Adult S's mother had been with Adult S at the family home for most of the day. It is understood that the mother left the house just before 20:00 to walk to the bus stop to catch a bus back to her house.
- 2.1.2 At around 20:05 on that day Adult S's niece went to the family home with her boyfriend to collect some belongings. Adult R answered the door and appeared to the niece to be behaving normally. Adult R told her and her boyfriend that Adult S was in the bath. They then both left at 20:20 when Adult R said that he was going to collect Child CC from a rehearsal at school.
- 2.1.3 At 20:31, Adult R's vehicle was seen on an automated number plate recognition (ANPR) camera on route to Child CC's school.
- 2.1.4 Child CC was collected by Adult R from the school sometime between 20:30 and 20:40.
- 2.1.5 Cell site and phone records show Adult S called Adult R's phone at 20:41 with the call emanating from the location of the family home.
- 2.1.6 Adult R's vehicle was seen again on an ANPR camera at 20:55 heading back towards the family home from Child CC's school.
- 2.1.7 Adult R killed Adult S and Child CC at some point after he and Child CC returned home, between 21:00 on 17 June 2015 and the early hours of 18 June 2015. Adult R had placed the bodies of Adult S and Child CC side by side in a bed and their bodies lay undiscovered until 09:37 on 29th June 2015
- 2.1.8 The post-mortem found that Adult S died as a result of compression to her neck and the probable cause of Child CC's death was suffocation.

2.2 The perpetrator's suicide

- 2.2.1 At 22.38 on 17 June 2015 Adult R made an on-line Eurostar reservation to travel to Calais.

- 2.2.2 At 00:58 on 18 June 2015 Adult R sent an email to Child CC's school tutor stating that there had been a family tragedy and that Child CC would not be in school until 29th June 2015.
- 2.2.3 At 04:36 Adult R's vehicle was seen on an ANPR camera driving on the M25.
- 2.2.4 At 06:20 Adult R caught the Eurotunnel to Calais. From here, Adult R proceeded to Lille where he met a French national with whom he had been having an extra-marital affair since April 2015.
- 2.2.5 Adult R was observed by her on this day to have a number of scratches on his face, neck and chest and a large bruise on his arm. She later described to Police that Adult R 'was not his usual self'.
- 2.2.6 They spent nine days together travelling between Paris, Cannes and Nice until she returned to Lille on 27 June 2015. That same day, Adult R contacted a friend in Turkey and asked to meet with him as he was 'in trouble'. This friend flew to France that day and met with Adult R at a flat owned by him (the friend) in Aix en Provence.
- 2.2.7 That evening, Adult R told him that he had killed Adult S and Child CC, falsely claiming that he had done so in a car accident. He advised Adult R that he should go to the Police and Adult R agreed to hand himself in the following day.
- 2.2.8 During the morning of 28 June 2015, he became concerned that Adult R had been in the bathroom for some time. He called the Police, who forced entry into the bathroom and found Adult R deceased on the bathroom floor in a pool of blood.
- 2.2.9 The French post mortem concluded that Adult R died from self-inflicted injuries, primarily from a large wound to his neck. He had two stab wounds and cuts to the inside of his arms.
- 2.2.10 At 08:34 on 29 June 2015 the friend contacted Surrey Police to advise of Adult R's suicide and to register his concern for the welfare of Adult S and Child CC following Adult R's disclosure that he had killed them.
- 2.2.11 At 09:37 Police attended the family home and discovered the bodies of Adult S and Child CC.
- 2.2.12 At 09:49 on 29 June 2015, the Independent Secondary School contacted Surrey Police to report significant concern that Child CC had not returned to school as

Adult R had outlined she would in his email of 18th June 2015. The school was informed that Surrey Police were attending the family's address.

2.3 Coroner's Inquest

2.3.1 On 23 November 2015 Her Majesty's Coroner for Surrey returned verdicts of unlawful killing in respect of Adult S and Child CC.

2.4 Information relating to Adult S

2.4.1 Adult S was 47 years old at the time she was killed. Adult S had been in a relationship with Adult R since they were at school. They married in 1999 in Barbados, although the marriage was not registered in the UK. Child CC, their only child, was born in May 2001.

2.4.2 Adult S apparently did not socialise much outside of her immediate family: mother, brother, niece and nephew. Her father had died in May 2014.

2.4.3 Adult S was self-employed and she and Adult R worked in corporate hospitality. Together, they had traded under several companies.

2.4.4 Adult S had accumulated significant debt and at the time of her murder was the subject of several County Court Judgements amounting to very large sums of money. The payment of Adult S and Adult R's joint mortgage was due on 18 June 2015, the date of the deaths.

2.5 Information relating to Adult R

2.5.1 Adult R was 50 years old at the time he took Adult S and Child CC's lives, as well as his own. Adult R had a small number of friends but was rarely in contact with his surviving family members: a brother and sister.

2.5.2 Adult R has been described by an employee as an out-going and charismatic man.

2.5.3 Adult R had also accumulated significant debts at the time of the murders and was also subject of several County Court Judgements.

2.6 Information relating to Child CC

- 2.6.1 Child CC was 14 years old at the time she was killed.
- 2.6.2 Staff at Child CC's school describe her as 'a lovely, kind and caring girl'. Child CC was performing well in school, was fully involved in school life and had good friends there.
- 2.6.3 During the course of the police investigation, some of Child CC's friends were interviewed by police. They describe Child CC as popular, thoughtful, funny and "crazy". She was a peacemaker, attentive to those who were upset and skilled in cheering everyone up. Child CC had recently cut her hair and donated it to the Little Princess Trust, to be made into a wig for young people with cancer.
- 2.6.4 Child CC was also 'very arty': she loved acting, singing, making films, taking photos, playing the piano, ice skating and YouTube. She attended an extra-curricular drama school and aspired to be seen as an actor, especially by her parents.
- 2.6.5 Outside of school, Child CC was usually busy with her family. She often spoke with her friends about her maternal grandmother, who she saw often. When friends visited or stayed at Child CC's house, which they did regularly, they would spend a lot of time in Child CC's bedroom and had to talk quietly or listen to music or films through headphones as Adult S and Adult R 'did not like noise'.
- 2.6.6 Child CC's friends and staff at her school describe Adult S and Adult R as being protective, sometimes over-protective, of Child CC.
- 2.6.7 On the evening of 17th June 2015, Child CC had performed a piece of prose which she had written as part of the Independent Secondary School Prose Festival. Review Panel members had the opportunity to read this piece of her work. Although, in order to protect Child CC's privacy, the Panel took the decision not to publish this piece of work in this report, it is of note that Panel members were moved by the maturity, talent and humanity that it captures of this bright young woman.

2.7 Child CC's health

2.7.1 Child CC was known to suffer with gastric problems. The school records reflect an awareness of a gastric ulcer problem and an associated prescription for proton pump inhibitor (PPI) medication. Police interviews with Child CC's friends reveal:

'Child CC couldn't eat certain foods and took tablets daily before and after food [...] the side effects of the tablets were not very good and Child CC hated all the blood tests she used to have.'

2.7.2 Child CC's friends were aware of a diagnosis of "leaky gut syndrome" (LGS). They knew that Child CC 'hated it and didn't like people knowing about it'. Recently Child CC had felt that the problem had been getting worse and her friends were aware that the symptoms could be very disabling:

'...it often made her feel really poorly and some days she couldn't even walk without being in pain.'

2.7.3 One of Child CC's friends had the impression that 'the doctors didn't actually know what was wrong with Child CC.'

2.8 Surrey Police

2.8.1 During the 1980s Adult R was known by a different name and was convicted for burglary, theft and vehicle related offences. He served a term of detention in youth custody, when he was about 18 years old. At some point after this episode, Adult R changed his name and there are no records on either the Police National Computer (PNC)¹ or the Police National Database (PND)² to indicate Adult R was suspected or known to have committed any further offences.

¹ The Police National Computer (PNC): The PNC is a national database of information available to all police forces and law enforcement agencies. The PNC holds details of personal descriptions, bail conditions, convictions, custodial history, wanted or missing reports, warning markers, pending prosecutions, disqualified driver records, cautions, drink drive related offences, reprimands, formal warnings. The PNC holds details of people who are, or were, of interest to UK law enforcement agencies because they: have convictions for criminal offences, are subject to the legal process, for example waiting to appear at court, are wanted, have certain court orders made against them, are missing or have been found, have absconded (escaped) from specified institutions, are disqualified from driving by a court, have a driver record held at the Driver and Vehicle Licensing Agency (DVLA), hold a firearm certificate.

² The Police National Database (PND) is available to all police forces and wider criminal justice agencies throughout the United Kingdom, allowing the police service to share local information and intelligence on a national basis. The PND supports delivery of three strategic benefits which are to safeguard children and vulnerable people, to counter terrorism, and to prevent and disrupt serious and organised crime.

- 2.8.2 There is no trace of Adult S on PNC or PND.
- 2.8.3 During the period under review, Adult S and Adult R came into contact with Surrey Police on four occasions: on 05 September 2010 when Adult S reported that Adult R had been the victim of a road rage incident; on 18 December 2014 and 03 March 2015 when a vehicle registered to Adult S was recorded by speed cameras driving at excess speed; and on 31 July 2012 when Adult S telephoned Police in relation to domestic abuse.
- 2.8.4 The contacts relating to road rage and speeding have been analysed and are not believed to hold any relevance to this review.
- 2.8.5 At 20:17 on 31 July 2012 Adult S contacted Surrey Police for advice in relation to on-going 'domestic issues' with Adult R. Adult S spoke with a male call taker at Surrey Police Contact Centre and enquired how she could stop Adult R from returning to their home. Adult S stated that they argue constantly and that Adult R had been physically violent towards her in the past.
- 2.8.6 The call taker established with Adult S that she had not reported any previous incidents of domestic abuse to Police and that she and Adult R jointly owned their home. The call taker then advised Adult S that there was nothing Police could do to stop Adult R entering the property.
- 2.8.7 Records state that Adult S became 'upset' and 'refused to be seen by the police'. Adult S explained to the call taker that she had friends in the area who would help her and she then terminated the call.
- 2.8.8 As the call taker was unable to obtain further information, a decision was made, in liaison with a supervisor and in line with Force policy, to pass the incident to the Force Control Room for police deployment. A police unit arrived at the home address at 21:44 nearly 90 minutes after the original call. There had been no police units available to attend prior to this due to a number of higher priority incidents.
- 2.8.9 The female police officer in attendance spoke with Adult R at the address who stated that he knew Adult S had called the police but he had not expected police to come to their home. Adult R stated that he had argued with Adult S earlier in the day but declined to provide any further details.
- 2.8.10 Adult R stated that he was packing to leave and also indicated that he would be speaking to his solicitor in relation to the police attendance. Adult R stated that

Adult S was not at the address. Adult R provided Adult S's phone number so that the police officer could call Adult S. This call took place out of earshot of Adult R.

- 2.8.11 Records of this phone call note that Adult S was 'angry' that police had attended the address and that she intended to make a complaint as she had been seeking advice only and that the police presence had 'made things ten times worse'. The police officer advised Adult S of Surrey Police procedures in respect of reports of domestic incidents, including positive action³, and how to make a formal complaint to the force.
- 2.8.12 Following the incident the attending police officer created a non-crime domestic incident report on the Crime Information System. The incident report additionally indicates that a male Acting Police Sergeant also made a phone call to Adult S with the intention of explaining the police procedures and to offer police assistance and specialist support services.
- 2.8.13 However, records note that Adult S 'did not take kindly' to the Acting Police Sergeant's call and said she would be making a formal complaint about him. There is no record to indicate that the intention to explain police procedures and offer police assistance and specialist support services was realised.
- 2.8.14 A Domestic Abuse, Stalking and Honour based Violence (DASH) risk indicator checklist was not completed. Surrey Police describe the reasons for this as 'lack of cooperation and minimal information provided by Adult S and Adult R'.
- 2.8.15 The incident report was reviewed first by a Police Sergeant and then by a Public Protection Investigation Unit (PPIU) Supervisor who concurred with the attending officer that the standard risk grading⁴ was appropriate. The Detective Sergeant determined that police should attempt no further contact with Adult S, reasoning that 'she had made it quite clear that she did not want police assistance'. The incident was filed and no further action taken.

³ Positive action: In every report of a crime officers must take positive action with the perpetrator including arrest where necessary. Officers in charge of an investigation will take positive action, normally meaning an arrest, at every report of breach of police/court bail, court injunction or non-molestation order to protect the victim and ensure that the courts become aware of the behaviour and actions of the perpetrator. Where possible this should include a charge and remand into custody for placing before a court.

⁴ Standard Risk Grading: The assessor uses the information from the risk identification interview with the victim to help them grade the level of risk as standard, medium, or high.

2.9 Independent Secondary School

- 2.9.1 Child CC joined the Independent Junior School in November 2008.
- 2.9.2 School medical notes show that in June 2009, the school was alerted that Child CC may be suffering a 'suspected severe disease'. In September 2010 the school nurse administered PPI medication to Child CC for a gastric ulcer. Communication with the school relating to Child CC's health needs was initiated by Adult R via email.
- 2.9.3 In 2011, the school were made aware of two incidents where Child CC had been hospitalised: On 07 March 2011 Child CC was admitted overnight to the Private Hospital with abdominal pain and vomiting; on 04 September 2011 Child CC was admitted to a local Hospital with pneumonia. Adult R emailed the school to inform them of both of these incidents and there were supporting medical notes that were shared.
- 2.9.4 In April 2014, the school's medical records indicate that Child CC continued to receive treatment for Leaky Gut Syndrome (LGS).
- 2.9.5 In July 2014 Adult S expressed concern that school staff were not adequately monitoring Child CC's food intake and preventing her from eating foods that were restricted in the management of her LGS. School staff noted that Adult S's behaviour seemed disproportionate to the incident.
- 2.9.6 In May 2015 Child CC's care plan was updated through a collaboration with the school nurse, Adult S and Child CC. It noted medications for allergies and hay fever and 'moderation in food' for the LGS.
- 2.9.7 At 00:58 on Thursday 18 June 2015 Adult R sent an email to Child CC's school tutor stating that there had been a family tragedy and that Child CC would not be in school until 29th June 2015.
- 2.9.8 Adult R's email was forwarded by Child CC's tutor to the Head of Year and Deputy Head who then sent it to the Headmistress. Telephone messages and emails were sent to both Adult R and Adult S.
- 2.9.9 On Friday 26 June 2015 the school telephoned Adult S's mother and brother to ask them to let Child CC know about a play rehearsal she was due to attend on

Sunday 28 June 2015. The mother and brother advised that they were not aware of a family tragedy.

2.9.10 Child CC was not present at the play rehearsal on 28 June 2015. An email exchange between the Headmistress, Head of Year and Deputy Head followed this absence, expressing concern. It was agreed that they would meet on Monday 29 June 2015 at 08:40 if Child CC was not in school.

2.9.11 On 29 June 2015, the school called Adult S's mother and brother to share their concern for Child CC and advised that they were going to call the police.

2.9.12 At 09:49 on 29 June 2015, the Independent Secondary School contacted Surrey Police to report significant concern for Child CC and her family. The school were advised that police were already attending the address.

2.10 Local GP Surgery Adult S

2.10.1 Adult S attended the GP practice with suspected urinary tract infections in September 2012, November 2013 and May 2014. On each occasion medication was prescribed but no further investigations were instigated which could have led to a consideration of other factors, e.g. the possibility of domestic abuse as an issue in Adult S's life.

2.10.2 In April 2013 and May 2015 Adult S did not respond to written reminders for smear tests and in March 2014 Adult S did not attend for a scheduled mammogram.

2.11 Local GP Surgery Child CC

2.11.1 During 2013 and 2014, Child CC presented at the GP surgery on two occasions with injuries. On each occasion the injuries seemed to be accompanied by credible causal explanations: in February 2013 she presented with a knee injury sustained through skiing and in September 2013 she presented with a superficial injury of her foot sustained through wearing shoes that were too tight.

2.11.2 In June 2014 Child CC presented at a walk-in centre with a bruised hand which was recorded as being sustained whilst playing with a dog.

2.11.3 There are no other records that indicate that Child CC may have been at risk of harm through domestic abuse.

2.12 Private Hospital - Adult S

- 2.12.1 Adult S had no contact with the Private Hospital during the timeframe under review. However, she had one outpatient consultation in November 2007 and one in April 2008. Although the reasons behind these consultations are not known, no tests or investigations were requested following either.
- 2.12.2 The resistance of the Private Hospital to engage with this review in a meaningful way is noteworthy.

2.13 Private Hospital - Child CC

- 2.13.1 During the timeframe under review Child CC had four contacts with the Private Hospital: in January 2011 she had an outpatient appointment with an adult chest physician, in March 2011 she was a general paediatric inpatient overnight, in September 2012 she had a paediatric outpatient appointment with an allergist and in November 2012 she had a paediatric outpatient appointment with a general paediatrician. Prior to this, dating back to July 2001, Child CC had a further eight paediatric outpatient appointments at the Private Hospital.
- 2.13.2 The sparse information provided to this Review by the Private Hospital does not provide adequate context or detail to understand these interactions.

3. Analysis

3.1 Domestic Violence / Abuse Definition

3.1.1 The government definition of domestic violence and abuse is:

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological; physical; sexual; financial; and emotional.

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

3.2 The Coordinated Community Response (CCR)

3.2.1 The CCR model recognises that no single agency can successfully resolve the inherent complexities of domestic abuse if acting alone. Whilst practice in agencies undoubtedly benefits from internal policies and procedures, without effective coordination of activities between agencies, responses are less effective and domestic abuse survivors will remain at risk of falling through the gaps in the system.

3.2.2 The inconsistent engagement of relevant health services with this review is therefore of deep concern to this Panel and, indeed, the wider local Community Safety Partnership. The consequent lack of information and analysis perpetuates our ignorance of potential problems, barriers and gaps and likely leaves unsafe practices unidentified and unresolved. The fundamental purpose of this review, to contribute to the prevention of further domestic homicides and improve responses for all domestic violence victims and their children, cannot therefore be fully realised.

3.2.3 The engagement and support of Surrey Police with this review has been commendable. It is imperative to recognise that the absence of information from relevant health services places upon Surrey Police a disproportionate burden in that they have been required to think about responding to domestic abuse in isolation from other services. This is contrary to the fundamental principle of collaboration which lies at the heart of the CCR. They have also been the one agency that had significant information about this case leading to a microscopic examination of their practice whilst others (particularly Health) have remained immune from examination, guidance or criticism. There is a danger that the inability to properly examine agencies that should or have been involved in these cases leads to an unbalanced outcome for all agencies.

3.3 Surrey Police

3.3.1 **Advice giving.** Through this review process, Surrey Police have identified that they gave inaccurate information to Adult S during the Contact Centre call. The information given was that there was nothing the police could do to stop Adult R from entering the family home. Positively, Surrey Police's own analysis has led to the identification of options available to victims in such circumstances: within the policing remit it has been identified that a removal of Adult R could have been actioned in order to prevent a breach of the peace; outside of the policing remit, it has been identified that Adult S could have sought to secure civil legal orders (e.g. occupation order⁵). The latter requires police to sign-post or refer victims on to other agencies, such as a family solicitor or specialist domestic abuse support service. The imperative to actively operate in partnership with other agencies in order to respond effectively to the multi-faceted risks and needs that arise from domestic abuse has been outlined in the section above (section 3.2) entitled *The Coordinated Community Response (CCR)*.

3.3.2 It is pertinent to note that this initial interaction between Adult S and Surrey Police began a deteriorating relationship between them that would worsen with each further contact (in a very short space of time) and eventually result in a breakdown

⁵ Occupation Order: An occupation order is an order issued by the court which sets out who has the right to stay, return or be excluded from a family home. An occupation order doesn't change the financial shares in a home. It is usually a short-term measure and the length of time that it lasts will depend on circumstances.

in meaningful communication. The opportunities to provide Adult S with sound advice about her options and safety were lost. It also made any likelihood of holding Adult R to account for any potential offences impossible.

- 3.3.3 This highlights the need for Contact Centre staff to be equipped to undertake these crucial initial responses to vulnerable victims with accurate and up-to-date information relating to domestic abuse as well as a clear pathway to support agencies outside of, and independent from the criminal justice remit. Recommendations (5 and 6) to reflect these needs are made in this Report.
- 3.3.4 **Escalation within police frameworks:** The escalation of the terminated call between Adult S and the Contact Centre, via a supervisor to the Force Control Room for police deployment, is not only a demonstration of compliance with domestic abuse procedures, but also an example of best practice. There was a deficit of information to establish whether there was a risk to life, risk of serious injury, or whether any party required medical attention so the decision to deploy a police officer to attend Adult S's address was critical.
- 3.3.5 **Escalation of risk of harm posed by Adult R to Adult S:** When the deployed police officer arrived at the family home, it became evident that Adult S was not present. It was not established whether Adult S had fled the address to stay with the 'friends in the area that would help her' who she had mentioned previously. It is important to acknowledge that these circumstances may have indicated to police a separation between Adult S and Adult R. Separation, which can happen in many forms from emotional to physical and temporary to permanent, is a known predictor of escalation. This was a missed opportunity to establish whether Adult S's absence from the home and Adult R's imminent departure, was likely to trigger an escalation in Adult R's abusive behaviour and increase the risk of harm to Adult S. (It is also true that Adult R could have been considered to be controlling the interface between the police and Adult S which may have been another indicator of a further risk factor.)
- 3.3.6 One study of domestic homicides in London (Richards, 2003) revealed that separation was a factor in 76% of intimate partner homicides. This is one of the factors that has led to the widespread employment of the DASH risk assessment, used by Surrey Police, to help staff identify risk and inform safety plans. It is therefore a great shame that such a form was not at least partially completed in

this case. As an example of relevance to this case the form includes the following question to guide enquiry around separation:

- Have you separated/tried to separate from Adult R within the past year? Yes/No. Include comments.

3.3.7 During the subsequent telephone conversation that took place between the police officer in attendance at the family home and Adult S, three issues were present in the conversations. Firstly, that Adult S seemed 'angry' that police had attended the address, to which the police officer responded with an explanation about Surrey Police procedures, including positive action. Secondly, that Adult S intended to make a complaint, to which the police officer responded with information about the force's formal complaints procedure. Thirdly that Adult S considered the police response as having 'made things ten times worse', to which there was no response from the police officer.

3.3.8 Adult S was giving a clear indication of escalation. Within the context of an abusive relationship, we know that escalation, both in frequency and severity of incidents, is a reliable indicator that the victim is at risk of significant further harm from the perpetrator's behaviour. Indeed, Surrey Police's DASH risk assessment guides enquiry around escalation as follows:

- Is the abuse happening more often? Yes/No. Include comments.
- Is the abuse getting worse? Yes/No. Include comments.

3.3.9 In this case, the risks associated with escalation, as well as those associated with possible separation are not considered by the police. It is clear that the dynamic that had evolved between Adult S and those representing Surrey Police was unproductive by this stage and rendered any further assessment of risk impossible, whether within the structured DASH format or more informally. However, the failure to consider the known risks continued through two further levels of supervision: that of the Acting Police Sergeant and the Public Protection Investigation Unit Supervisor.

3.3.10 Surrey Police express confidence that additional domestic abuse training for response officers has greatly improved their approach in this domain. A

recommendation (8) is made in this Report in relation to the monitoring and evaluation of this assertion. A further recommendation (7) is made in this Report to reflect the need for enhanced domestic abuse risk identification training for supervisors.

- 3.3.11 Although the action of the Acting Police Sergeant in making a further call to Adult S to attempt to offer help is commendable, it ultimately did not achieve any reduction in the known risks. At both these supervisory stages, it is critical to consider how to activate support from services within the wider community network, such as specialist domestic abuse support services, whose independence, skills and knowledge may be able to engage survivors when the police cannot. This is another example of the importance of a CCR.
- 3.3.12 The Panel acknowledges the potential merit in creating a referral pathway from Surrey Police to the local Domestic Abuse Outreach Service in cases where Police have not been able to complete a DASH and, subsequently, do not have any adequate information on which to categorise the level of risk to the victim (i.e. standard / medium / high). The panel equally acknowledges the barriers associated with making such referrals without the consent of the victim as well as the resource implications that accompany the inevitable increase in demand on Domestic Abuse Outreach services. A recommendation (4) for the CSP to undertake a cost-benefit analysis of implementing this additional pathway is made in this Report. It may be that action is agreed on the basis that an inability to complete a risk assessment automatically suggests it is a high risk case leading to the appropriate referral.
- 3.3.13 **Child Protection:** Although the police had contact with Adult R on one occasion (deployed police officer) and with Adult S on three occasions (Contact Centre, deployed police officer, Acting Police Sergeant) during this incident, neither party was asked whether they had any children. This meant that Child CC's presence within the home was not identified and that any associated risks to her or needs arising from the domestic abuse were not assessed.
- 3.3.14 Through the process of this review, Surrey Police have identified that this information should have been established. Had this happened, Surrey Police

would then have taken steps to see Child CC and completed a 39/24 form⁶. This latter procedure would have led to other agencies, including Surrey Children's Services and possibly the Independent Secondary School, being made aware of the domestic abuse and given opportunities to intervene early or offer help to Child CC and Adult S. Surrey Children's Services would then have been in a position to consider action to safeguard Child CC and explore Adult R's role within the family and as a perpetrator of abuse. However, the Panel believes it unlikely that any intervention would have taken place as the circumstances would not have met the threshold for Children's Services action. If relevant and proportionate information from the 39/24 form had been shared with the school, they may have discussed life at home with Child CC, which could have led to disclosures or greater understanding of the context to Child CC's life.

- 3.3.15 The Panel notes the value of sharing relevant and proportionate information from the 39/24 form with appropriate agencies including schools, and Surrey Police are indeed pursuing the best practice Operation Encompass⁷ model of information sharing with schools. A recommendation (3) relating to improved dissemination of information from Police regarding vulnerable people is made in this Report.
- 3.3.16 Surrey Police express confidence that the procedures relating to the identification and safety of children are now, almost four years later, embedded within practice and undertaken as a matter of course. A recommendation (8) relating to the monitoring and evaluation of this is made in this Report.
- 3.3.17 **The "one chance" rule:** It is striking how little contact Adult S had with services during the timeframe under review. We have found little material to inform what services could do to build better bridges to reduce this kind of distance between Adult S, and other survivors like her, and those who have the power and duty to help. Adult S's isolation from support only serves to frame the police response to her exclusive reach for help as vitally important. This unique episode in Adult S's

⁶ 39/24 form: Used by Surrey Police to report contact with a child or vulnerable adult. Completed by an attending officer and forwarded to the relevant PPIU for review, any further action, and shared with Surrey County Council Contact Centre. Since April 2011, all completed 39/24s are forwarded to the Surrey Police Central Referral Unit (CRU) for review and sharing with partner agencies.

⁷ Operation Encompass: Operation Encompass was created so that by 9.00am on the next school day, a 'Key Adult' will be informed that the child or young person has been involved in or witnessed a domestic incident. This knowledge, given to schools through Operation Encompass, allows the provision of immediate early intervention through 'overt' or 'silent support', depending upon the needs and wishes of the child. We believe that this kind of early intervention is every child's right. (<http://www.operationencompass.org/>)

life offered the police something akin to the “one chance” rule associated with Forced Marriage and Honour-Based Violence:

All professionals working with suspected or actual victims of forced marriage and honour based violence need to be aware of the “one chance” rule. That is, they may only have one opportunity to speak to a victim or potential victim and may possibly only have one chance to save a life. As a result, all professionals working within statutory agencies need to be aware of their responsibilities and obligations when they are faced with forced marriage cases. If the victim is allowed to leave without the appropriate support and advice being offered, that one chance might be wasted. (HM Government, 2014, p.16)

3.3.18 There is a clear parallel with the unfulfilled potential of Adult S’s sole domestic-abuse-related interaction with the police to act as a conduit to information, help and safety. There are two inter-related learnings to be found, not only for the police but for any agency to whom Adult S may have made that unique approach for help, within the domains of co-production and the coordinated community response.

3.3.19 **Co-production:** Co-production is concerned with ‘enlisting people as co-producers of public services’ (Stephens et al, 2008, p.1):

Professionals need their clients as much as the clients need professionals. In practice, the consumer model of public services – where professional systems deliver services to grateful and passive clients – misses out what is most effective about their ‘delivery’: the equally important role played by those on the receiving end, without which, doctors are almost powerless to heal, just as teachers are powerless to teach and police to prevent crime (Stephens et al, 2008, p.8).

3.3.20 At the core of the model is a definition of clients as assets and an understanding that where this is ignored, both sides are destined to fail.

3.3.21 The police relationship with Adult S seemed not to value, or at least undervalued Adult S as a co-producer of safety and justice. This is most visible in the language used by police to record Adult S’s behaviour (see Appendix 1 for examples) and may point to an opportunity to develop a model of co-production.

- 3.3.22 A recommendation (2) is made in this Report for the Community Safety Partnership to consider ways in which to utilise co-production to improve practice with victims / survivors of domestic abuse.
- 3.3.23 **The Coordinated Community Response (CCR).** The police response to Adult S's approach for help did not realise its' potential to activate other parts of a wider system to respond to the needs that arose from Adult R's abuse of Adult S. A critical opportunity to offer or refer Adult S to a specialist domestic abuse support service, in this case the local Domestic Abuse Outreach Service, was missed.
- 3.3.24 A recommendation (4) is made in this Report for the CSP to undertake a cost-benefit analysis to establish the viability of implementing an additional referral pathway between police and Domestic Abuse Outreach services in cases where the DASH risk assessment system has not been successfully completed.

3.4 Independent Secondary School

- 3.4.1 Throughout the six and a half years that that Child CC attended the Independent Junior and Secondary Schools, the schools received no obvious evidence to alert them to the possibility that Child CC was living in a household where there was domestic abuse. This has given rise to the recommendations (9 and 10) in this report for the Independent Secondary School to consider more active ways in which the school can encourage and initiate dialogue around domestic abuse and publicise ways that children and young people can make disclosures.
- 3.4.2 The Independent Secondary School would have had the opportunity to draw potential links between Child CC's health complaints and witnessing domestic abuse at home, had they received the relevant and proportionate information from the 39/24 form from police following the incident of 31st July 2012.
- 3.4.3 Following Adult R's email to the Independent Secondary School on 18th June 2015 which advised that Child CC would be absent from school for a period of seven school days due to a 'family tragedy', the Independent Secondary School complied with their Child Protection and Attendance policies.
- 3.4.4 It is a matter of some conjecture whether GHS would have alerted police at an earlier stage of Child CC's absence, if they had been in possession of the 39/24 form and consequently aware of Adult R's abusive behaviour. Further conjecture

arises as to whether the police would have been able to locate Adult R within the ten-day window before his suicide and bring him to justice.

3.5 Local GP Surgery Adult S

3.5.1 Repeat presentation with UTIs could reasonably trigger a process of opportune enquiry around domestic abuse. There is an appetite for the IRIS⁸ (Identification and Referral to Improve Safety) programme to be rolled out in the local Borough and a recommendation (11) is made in this Report to reflect that.

3.6 Local GP Surgery Child CC

3.6.1 There is no evidence to indicate that the GP practice could have responded differently with the presentations that Child CC made.

3.7 Private Hospital - Adult S

3.7.1 The Panel expressed concern about the diagnosis of Child CC with LGS as it is not widely recognised by medical professionals as a legitimate illness. The Panel questioned whether the symptoms Child CC was experiencing could have been psychosomatic, caused by the stress of living in an abusive household.

3.7.2 Without further information from the healthcare provider, it is impossible to establish what enquiry took place by the diagnosing physician or how eagerly Adult R may have pursued a diagnosis of LGS, either to distract those around Child CC from drawing links between her poor health and an abusive home life, or to deny to himself, Adult S and Child CC the impact of his abusive behaviour on Child CC's wellbeing.

3.7.3 It is woefully inadequate that the Private Hospital has not provided sufficient information to support this Review. A recommendation (13) is made in this report for the Home Office to hold private health care providers accountable to both the domestic homicide and serious case review process.

⁸ <http://www.irisdomeesticviolence.org.uk/iris/>

3.8 Private Hospital - Child CC

- 3.8.1 The sparse information provided to this Review by the Private Hospital does not provide adequate context or detail to identify whether Child CC disclosed any information that could have reasonably triggered enquiry around domestic abuse.
- 3.8.2 The fragmentation that occurs in the narrative of Child CC's contact between private and NHS health services is notable. A recommendation is made in this report (14) for NHS England to respond to the gaps that emerge between care providers and threaten the safety of adult and child survivors of domestic abuse.

4. Conclusions and Recommendations

4.1 Preventability

- 4.1.1 The precise nature of domestic violence and abuse is well known to those agencies who so regularly deal with victims, their children and perpetrators. The evidence of many DHRs is that opportunities nearly always exist where a different approach could have led to opportunities being grasped where the fatal outcome could have been averted. In this sense this is true in this case and, if preventability is defined in its widest sense, there is a possibility that the deaths of Adult S and Child CC could have been prevented.
- 4.1.2 This case highlights how fleeting and limited such opportunities can be. There should be no avoiding of the fact that in some way the police, the school and the GP practice in this case can now enhance their practice to consider whether domestic violence is present, what level of risk is posed and what action can be taken to mitigate that risk and support the vulnerable. This is the true benefit of DHRs and the recommendations will lead to a more responsive, aware and effective practice within a Coordinated Community Response.
- 4.1.3 With this in mind this case also illustrates the difficulty of predicting such events. The time lapse between the one report of domestic abuse and the deaths shows how difficult it is to assess the outcome of abusive relationships. On the evidence available it cannot be said that these killings were predictable, although that must never obscure the fact that such abuse is almost always accompanied by the dynamic of escalation and that the abuse or violence will worsen.

4.2 Conclusions

- 4.2.1 There is a paucity of information about the true nature of the relationship between Adult R, Adult S and Child CC. Whilst it is known that Adult S had reported domestic abuse in 2012 and that they were in financial difficulties, there is very little evidence on which to base strong and detailed conclusions. This, though, is often the nature of domestic relationships which are abusive. It is for this reason that the level of intervention and the expertise necessary to deal with such matters is the subject of much consideration, training, policy and practice. It is only through

agencies working together, in a Coordinated Community Response, that such improvements can be achieved.

- 4.2.2 According to the policies of the time (especially in the case of the police in 2012) this case was dealt with in a “standard” way. This is a vast improvement from earlier times but this review amply demonstrates that development is still necessary. The recommendations below are designed to build upon changes that have been instituted and become commonplace and also take the agencies to the next level where the prevalence of domestic violence or abuse and its nature are addressed more comprehensively and with the improved understanding of its dynamics.

4.3 Partnership Arrangements

- 4.3.1 **Recommendation 1** - CSP analyse their existing response to domestic abuse and seek to develop a more complete and enhanced approach to this issue through the mechanism of a Coordinated Community Response to domestic abuse.
- 4.3.2 **Recommendation 2** – Develop and trial individual and community interventions using the concept of co-production, to enhance the borough’s response to victims of domestic abuse.
- 4.3.3 **Recommendation 3** – Ensure that the agreed intention of providing Police information about vulnerable people to relevant agencies, including schools is promulgated with urgency.
- 4.3.4 **Recommendation 4** – Undertake a cost-benefit analysis to establish the viability of implementing an additional referral pathway between police and Domestic Abuse Outreach services in cases where the DASH risk assessment system has not been successfully completed.

4.4 Surrey Police

- 4.4.1 **Recommendation 5** – Deliver training for Contact Centre staff to ensure a sound grasp of the dynamics of domestic violence and to equip them with the skills and information necessary to respond appropriately to victims of domestic abuse.
- 4.4.2 **Recommendation 6** – Develop for all frontline staff (including staff in contact centres and control rooms) clear referral pathways to specialist domestic abuse support services and related agencies.

4.4.3 **Recommendation 7** – Provide enhanced risk identification and awareness training to ensure Public Protection Unit supervisors have adequately informed oversight of domestic abuse cases.

4.4.4 **Recommendation 8** – Surrey Police to use this DHR process and the development from the recommendations to audit its policies and practice to ensure the developments are embedded in practice (within 6 months of publication of the report).

4.5 Independent Secondary School

4.5.1 **Recommendation 9** – Integrate domestic abuse awareness into safeguarding training for all staff (and ensure those staff already trained in safeguarding receive this training).

4.5.2 **Recommendation 10** – Integrate the Spiralling⁹ toolkit into PSHE (personal, social, health and economic) education.

4.6 NHS General Practice in the local Borough

4.6.1 **Recommendation 11** – Request the Joint Commissioning Board to commission the IRIS programme within the area.

4.7 National Recommendations

4.7.1 The CSP should be informed of the outcome of the following recommendations which go beyond a purely local remit.

4.7.2 **Recommendation 12** – Debt advisory services to develop a system where those individuals with County Court Judgements (or similar) relating to debt are provided with information about domestic abuse support services and support to assist in the resolution of the case.

4.7.3 **Recommendation 13** – HM Government to develop the statutory guidance for DHRs to specifically include private medical care and oblige such organisations to participate in the DHR process.

⁹ https://www.tamesidesafeguardingchildren.org.uk/resources/materials/toolsandresources/spiralling/spiralling_toolkit.pdf

- 4.7.4 **Recommendation 14** - NHS England to respond to the gaps that emerge between private and national health care providers which may threaten the safety of adult and child survivors of domestic abuse.

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Appendix 1: Co-production

Table of examples to show how the application of the values of co-production can support improved risk identification and response.

Terminology used in police recording	Interpretation problems	Co-productive reframe	Potential positive impact of re-framing interaction
'Adult S asked the call taker for advice regarding on-going <u>domestic issues</u> with her husband'.	The term used here does not reflect the motivation for Adult S's approach for help: the abusive nature of the behaviour Adult S had been subjected to from Adult R. Nor does it reflect the severity of abuse that Adult S disclosed, which included physical violence.	Adult S was taking initiative to seek help in relation to <u>domestic abuse</u> from her husband.	This record cites Adult S as an active agent in the interaction and reflects that abusive nature of Adult R's behaviour has been heard by the police.
'Adult S became <u>upset</u> '.	This behaviour seems to be measured against the expectation that Adult S will be 'grateful and passive'. It is not received as expression of distress from which police can understand important messages about risks to Adult S.	Adult S's behaviour seemed to me to be communicating a distress [specify behaviours e.g. crying, shouting, silent etc.] due to the absence of options to help her be safe from her husband's abusive behaviour.	This record focuses on the value of the messages that Adult S's behaviour conveys to police about the risks she is facing. It recognises the contribution that police have made to her distress, in that they are unable to offer help. It cites Adult R's behaviour as the root cause of Adult S's distress. It also makes clear that further action is required by police to make links to others who <i>can</i> help.
'Adult S was <u>angry</u> that police had attended the address'.	This behaviour seems to be measured against the expectation that Adult S will be 'grateful and passive'. It is not	Adult S's behaviour seemed to me to be communicating a distress [specify behaviours e.g. crying,	This record focuses on the value of the messages that Adult S's behaviour conveys to

	received as expression of distress from which police can understand important messages about risks to Adult S.	shouting, silent etc.] due to the escalation in risk to her safety that the police presence at the house had caused.	<p>police about the risks she is facing.</p> <p>It recognises the contribution that police have made to her distress.</p> <p>It also makes clear that further action is required by police to work with Adult S, and perhaps others, to respond to the escalated risk.</p>
'Adult S stated that [...] police presence had made things ten times worse.'	The recording of this information is important but there is an absence of a call for further investigation and action.	Adult S's assessment of the circumstances is one of significantly increased risk. It seems that we have exhausted the possibilities of engaging effectively with Adult S to understand what is needed to manage this increased risk. We need to consider which other agencies would be able to help/intervene here.	This record accepts Adult S as the expert in assessing the risks posed to her by Adult R. It acknowledges the limits of the police role but highlights that other agencies may be able to step-in to respond to the increased risks. It is clear that further action is required by police to activate a multi-agency response.
'Adult S did <u>not take kindly</u> to the call'.	This behaviour seems to be measured against the expectation that Adult S will be 'grateful and passive'. It is not received as expression of distress from which police can understand important messages about risks to Adult S.	Adult S's behaviour seemed to me to be communicating a continued distress [specify behaviours e.g. crying, shouting, silent etc.] due to the escalation in risk to her safety that the police intervention had caused.	<p>This record focuses on the value of the messages that Adult S's behaviour conveys to police about the risks she is facing.</p> <p>It recognises the contribution that police have made to her distress.</p> <p>It also makes clear that further action is required by police to work with Adult S, and perhaps others, to respond to the escalated risk.</p>

<p>'Adult S <u>refused</u> to be seen by the police'.</p>	<p>The essence of 'refusal' is to not being <i>willing</i>. However, in the context of an abusive relationship it is far more likely that Adult S did not feel <i>able</i>.</p>	<p>Adult S is extremely fearful of the consequences of engaging with the police at this time. This barrier appears to me to be unsurmountable.</p>	<p>This re-balances the power dynamic between Adult S and police.</p> <p>It acknowledges the level of fear that Adult S is experiencing.</p> <p>It necessitates action to identify those services who may be able to overcome the barrier that the police are facing.</p>
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Appendix 2: Terms of Reference

Terms of Reference for the joint Domestic Homicide & Serious Case Review for Adult S and Child CC

This Domestic Homicide Review is being completed to consider agency involvement with Adult S, Child CC and Adult R following the deaths of Adult S and Child CC on the 18th June 2015. The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004. A serious case review ran jointly to ensure fair consideration of these events on Child CC.

Purpose - DHR

1. Domestic Homicide Reviews (DHRs) place a statutory responsibility on organisations to share information. Information shared for the purpose of the DHR will remain confidential to the panel, until the panel agree what information should be shared in the final report when published.
2. To review the involvement of each individual agency, statutory and non-statutory, with Adult S and Adult R during the relevant period of time: **1st June 2010 – 29th June 2015**.
3. To summarise agency involvement prior to **29th June 2015**.
4. To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to identify and respond to disclosures of domestic abuse.
5. To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result and as a consequence.
6. To improve inter-agency working and better safeguard adults experiencing domestic abuse and not to seek to apportion blame to individuals or agencies.
7. To commission a suitably experienced and independent person to:
 - a. chair the Domestic Homicide Review Panel;
 - b. incorporate the SCR process
 - c. co-ordinate the review process;
 - d. quality assure the approach and challenge agencies where necessary; and
 - e. produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established terms of reference.
8. To conduct the process as swiftly as possible, to comply with any disclosure requirements, panel deadlines and timely responses to queries.
9. On completion present the full report to the local Community Safety Partnership.

Purpose – SCR

10. Meet the requirements for Serious Case review with regard to Child CC and specifically to:
- a. Establish 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 promote the welfare of children;
 - 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; and
 - c. Improve intra- and inter-agency working and better safeguard and promote the welfare of children.

Membership

11. It is critical to the effectiveness of the meeting and the DHR that the correct management representatives attend the panel meetings. Your agency representative must have knowledge of the matter, the influence to obtain material efficiently and can comment on the analysis of evidence and recommendations that emerge.
12. The following agencies are to be invited to participate:
- a. Clinical Commissioning Groups (formerly known as Primary Care Trusts)
 - b. General Practitioner for the victim and **alleged** perpetrator
 - c. Local domestic violence specialist service provider e.g. IDVA
 - d. Education services
 - e. Children's services
 - f. Adult services
 - g. Health Authorities
 - h. Substance misuse services
 - i. Housing services
 - j. Local Authority
 - k. Local Mental Health Trust
 - l. Police (Borough Commander or representative, Critical Incident Advisory Team officer, Family Liaison Officer and the Senior Investigating Officer)
 - m. Prison Service
 - n. Probation Service
 - o. Victim Support (including Homicide case worker)

13. Where the need for an independent expert arises, for example, a representative from a specialist BME women's organisation, the chair will liaise with and if appropriate ask the organisation to join the panel.
14. If there are other investigations or inquests into the death, the panel will agree to either:
 - a. run the review in parallel to the other investigations, or
 - b. conduct a coordinated or jointly commissioned review - where a separate investigation will result in duplication of activities.

Collating evidence

15. Each agency to search all their records outside the identified time periods to ensure no relevant information was omitted, and secure all relevant records.
16. Each agency must provide a chronology of their involvement with Adult S, Child CC and Adult R during the relevant time period.
17. Each agency is to prepare an Individual Management Review (IMR), which:
 - a. sets out the facts of their involvement with Adult S, Child CC and/or Adult R;
 - b. critically analyses the service they provided in line with the specific terms of reference;
 - c. identifies any recommendations for practice or policy in relation to their agency, and
 - d. considers issues of agency activity in other boroughs and reviews the impact in this specific case.
18. Agencies that have had no contact should attempt to develop an understanding of why this is the case and how procedures could be changed within the partnership which could have brought Adult S, Child CC or Adult R into contact with their agency.

Analysis of findings

19. In order to critically analyse the incident and the agencies' responses to the family, this review should specifically consider the following six points:
 - a) Analyse the communication, procedures and discussions, which took place between agencies.
 - b) Analyse the co-operation between different agencies involved with the victim, alleged perpetrator, and wider family.
 - c) Analyse the opportunity for agencies to identify and assess domestic abuse risk.
 - d) Analyse agency responses to any identification of domestic abuse issues.
 - e) Analyse organisations access to specialist domestic abuse agencies.
 - f) Analyse the training available to the agencies involved on domestic abuse issues.

Liaison with the victim's and alleged perpetrator's family

20. We aim to sensitively involve the family of the victim in the review, identifying the most appropriate method and route of contact.
21. We also aim to explore the possibility of contact with any of the alleged perpetrator's family who may be able to add value to this process.
22. The chair will lead on family engagement with the support of relevant Panel members, including coordination of family liaison to reduce the emotional hurt caused to the family by being contacted by a number of agencies and having to repeat information.
23. Coordinate with any other review process concerned with the child of the victim and alleged perpetrator.

Development of an action plan

24. Individual agencies will take responsibility to establish clear action plans for agency implementation as a consequence of any recommendations in their IMRs. The Overview Report will set out the requirements in relation to reporting on action plan progress to the Community Safety Partnership: for agencies to report to the CSP on their action plans within six months of the Review being completed.
25. Community Safety Partnership to establish a multi-agency action plan as a consequence of the recommendations arising out of the Overview Report, for submission to the Home Office along with the Overview Report and Executive Summary.
26. SSCB Serious Case Review Group to act on the recommendations arising out of the report in relation to Child CC.

Media handling

27. Any enquiries from the media and family should be forwarded to the chair who will liaise with the CSP. Panel members are asked not to comment if requested. The chair will make no comment apart from stating that a review is underway and will report in due course.
28. The CSP is responsible for the final publication of the report and for all feedback to staff, family members and the media.

Confidentiality

29. All information discussed is strictly confidential and must not be disclosed to third parties without the agreement of the responsible agency's representative. That is, no

material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.

30. All agency representatives are personally responsible for the safe keeping of all documentation that they possess in relation to this DHR and for the secure retention and disposal of that information in a confidential manner.
31. It is recommended that all members of the Review Panel set up a secure email system, e.g. registering for criminal justice secure mail, nhs.net, gsi.gov.uk, pnn or GCSX. Confidential information must not be sent through any other email system. Documents can be password protected.

Disclosure

32. Disclosure of facts or sensitive information may be a concern for some agencies. We manage the review safely and appropriately so that problems do not arise and by not delaying the review process we achieve outcomes in a timely fashion, which can help to safeguard others.

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