Safe in the city
Brighton & Hove Community Safety Partnership

east sussex
safer
communities
partnership

Overview Report of the Domestic Homicide Review relating to the death of Mrs B

Executive Summary

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Acknowledgements

This was a tragic event in which a young woman died. She was well liked and demonstrated drive and achievement during her short life.

The Domestic Homicide Review (DHR) Panel want to put on record their appreciation of the contribution made to this DHR by the family of Mrs B, who shared information that brought vividness to this tragedy for all concerned. The Chair also met with Mr B (the perpetrator), and with [redacted], who shared information that contributed to the review.

From these discussions the Panel gained a depth of information and understanding that has been incorporated into the considerations and recommendations in this DHR, alongside the engagement and perspectives of Mrs B's employer and from the agencies that provided Individual Management Reports.

Executive Summary

Introduction

This Domestic Homicide Review (DHR) has been jointly commissioned by the Community Safety Partnerships (CSPs) of Brighton & Hove (the Safe in the City Partnership) and East Sussex (the East Sussex Safer Communities Partnership), in accordance with *Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews* published by the Home Office in March 2011.

This was a terribly sad and tragic event that took the life of a young woman well liked and energetic. At the same time this has blighted the life of her husband who committed this act.

Incident

On Sunday evening 17th February 2013 Mrs B was fatally stabbed outside her place of work in Brighton by her husband Mr B. The police were alerted by calls from members of the public to this incident.

Mr B was apprehended at the scene and Mrs B taken to hospital where she was declared dead at 10 pm.

Mr B was tried and found guilty of murder on 26th July 2013. He was sentenced to a minimum of 25 years in prison.

Background

Neither person was well known to services, and nor were the strains within their relationship well known. Mr B had sought psychological support in the past and in the months before this act for his low mood in relation to bereavements he had suffered. He was identified as having a moderately severe depression. Mr B was offered a psychological intervention through the Health in Mind service, but this was not taken up. This appears to be because he did not see the appointment letter and, when the referral was discussed with his GP, Mr B expressed some concern about accessing the service.

There had been contact with Bedfordshire Police in April 2011 in regard to a domestic incident which was not well documented and, in line with the existent policy at that time, did not prompt referral to a specialist domestic abuse support service.

An issue that emerges is that Mr B had experienced bullying while he was at school, and [redacted] It is not possible to identify any causal connection with Mr B's subsequent behaviour and it would be inappropriate to seek to stretch such knowledge as the panel had in this way. However, there were concerns that can be identified in retrospect in regard to previous relationships that may be relevant.

This points to the importance more generally of wider societal awareness and understanding of domestic abuse, and we have included this in the range of our recommendations.

A retrospective consideration of all that is now known, but not known at the time, can be construed as indicating that Mr B might abuse a partner if under stress or feeling rejected, but there is nothing to indicate that he might kill a partner as he did. There is no evidence that leads to a view that this event might have been predicted.

The Panel has identified good practice by the Neighbourhood Policing Team in a chance encounter with Mr and Mrs B and others outside their home when they proactively offered support to him. It is also the case that the Senior Investigating Officer made a commendable contribution to how Mrs B's employers were able to support their staff deal with this event which happened immediately outside the company's office.

The Panel has made nine recommendations from its consideration of this case which are set out below:

Recommendation 1:
Records should be consistently completed, in order to provide:

- **An accurate record of an incident**
- **The actions of officers at the time**
- **What was known to police officers at the time of the incident**

Where there are discrepancies between the Incident Log and Domestic Incident Crime Report, these are resolved to ensure a full understanding of the current situation and any further action.

Recommendation 2:
That all domestic abuse incidents (not just crimes) are offered a referral to a specialist domestic abuse service.

Recommendation 3:
That information is provided directly to victims of domestic abuse at or following an incident (where it is safe to do so) that might encourage them to identify ongoing abuse in the relationship and know where to seek help.

Recommendation 4:
That the proposed DHR working group, under the auspices of the Pan Sussex Domestic Abuse Steering Group, is established with a view to developing a protocol to ensure a consistent DHR process across Sussex, including information sharing. This would also promote sharing learning and recommendations locally, regionally and nationally.

Recommendation 5:
The NHS England local Area Team works with the relevant Clinical Commissioning Groups to develop a consistent process to support practitioners' awareness of domestic abuse, including access to an appropriate specialist service, in a primary care setting. Examples include the domestic abuse health advocate/educator within the IRIS model[1].

Recommendation 6
Where people are contacted offering them a psychological intervention, it is made very clear what the contact arrangements are, where the service might be offered and the nature of the contact, i.e., as an initial session in a series of sessions, or as an initial assessment, or as a one-off session.

Recommendation 7:
Develop a consistent process to support practitioners having access to an appropriate specialist service in Accident and Emergency, for example, a Health Independent Domestic Violence Advisor (HIDVA).

Recommendation 8:
That the Community Safety Partnership identifies how to support local businesses in regard to domestic violence and abuse, including raising awareness of this issue among staff, ensuring that employers know how to respond to domestic violence and abuse, and having the capacity to offer proactive support in the event of a serious incident or homicide.

Recommendation 9:
That the Community Safety Partnership reviews the information available to victims/survivors, friends and families about:

- **What domestic violence and abuse is**
- **The support available**
- **How to access help**

The purpose of this review is to ensure that this information is routinely accessible as part of sustained community awareness campaigns, in addition to delivering targeted interventions such as preventative education in schools.

[1] Identification and Referral to Improve Safety' in General Practice.