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

Report produced by:

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Independent Chair of the Domestic Homicide Review Panel

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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.

1 Introduction

1.1 Background to the Domestic Homicide Review

On the evening of Sunday 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.

1.2 Commissioning this DHR

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.

Sussex Police notified the Safe in the City Partnership on the 8th March 2013 that the case should be considered as a DHR, as Mrs B has been residing in the city at the time of her murder. However, as Mrs B had previously been domiciled in East Sussex, the Safe in the City Partnership consulted with the East Sussex Safer Communities Partnership before making a decision to conduct a DHR. Having agreed to undertake a review, the Home Office was notified of the decision on the 11th March 2013. An initial meeting was held on the 22nd April 2013 between the representatives from the Safe in the City Partnership, the East Sussex Safer Communities Partnership and Sussex Police to establish the scope of the DHR, as well as to identify how it would dovetail with the then ongoing criminal investigation.

The Executive Summary, Overview Report and Action Plan were presented to the Safe in the City Partnership on the 26th November 2013 and the East Sussex Safer Communities Partnership on the on 17th December 2013. They were submitted to the Home Office on the 3rd February 2013 and were considered at the April 2014 meeting of the Home Office Quality Assurance Panel. The report was judged 'adequate', with the Home Office providing notification and approval for publication on the 13th June 2014 (see Appendix One).

Once published, the final report will be shared with the governance boards and committees of participating statutory agencies, in addition to the Violence against Women and Girls (VAWG) Programme Board and VAWG Forum in Brighton & Hove, the East Sussex Safeguarding Adults at Risk Board and Domestic Abuse Steering Group, and the Pan Sussex Domestic Abuse Steering Group The final report will also be shared with the Luton CSP.

Purpose

The purpose of this DHR is extracted from the Statutory Guidance, point 3.3:

- *Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;*
- *Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;*
- *Apply these lessons to service responses including changes to policies and procedures as appropriate; and*
- *Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.*

1.3 Terms of Reference

Draft Terms of Reference were proposed in April 2013 to give guidance to the agencies providing Individual Management Reviews, and these were endorsed at the first meeting of the DHR Panel in June 2013. The names and dates of birth of the victim and the perpetrator were included in the Terms of Reference but have subsequently been anonymised.

Domestic Homicide Review into the death of Mrs B

Specific Terms of Reference for this DHR

1. *To commission, review and analyse agency Individual Management Reviews (IMRs).*

2. *To examine the engagement and the support offered by relevant agencies to Mrs B, and her partner Mr B jointly and separately since January 2011.*

   The DHR is also seeking information in regard to both Mrs B and Mr B in relation to their respective adolescences and childhoods and relevant agencies in East Sussex and Luton are requested to review their historic records.

   The DHR Panel may vary this time span dependent on information received in the Individual Management Reviews

3. *To examine the adequacy of the operational policies and procedures applicable to this engagement and whether staff complied with them.*

4. *To examine the adequacy of collaboration, communication and information sharing between all of the agencies involved, including between different areas of the country as necessary.*

5. *To form a view on practice and procedural issues that emerge in considering the circumstances of this case and any lessons from this engagement that can be generalised to other situations where domestic violence is known of or suspected.*

6. *To agree the key points to be included in the report, recommendations and the formulation of an Action Plan to implement any recommendations.*

7. *To seek independent expert advice if the Panel is agreed that such a contribution to the DHR is necessary.*

8. *To address any other matters that may arise as the DHR progresses.*

9. *To support the Independent Chair in preparing a written report that includes recommendations so that, as far as is possible, in similar circumstances in the future, learning is taken forward and care is effective and efficient.*

10. *To prepare an anonymised Overview Report that can be made public.*

11. *To prepare an Action Plan addressing the DHR's recommendations to be presented to the Brighton & Hove CSP (Safe in the City), the East Sussex CSP (Sussex Safer Communities Partnership) and made available to the Luton CSP), as well as the relevant Safeguarding Adults Boards and Domestic Abuse Forums.*

12 *To consider media arrangements for the publication of the DHR.*

The Review will conduct its work in private but will engage the relatives, friends and work colleagues of Mrs B as is appropriate

Timetable
The precise timetable will be dependent on a number of factors including the Review Team's need to collate and cross reference all of the information, and the criminal proceedings underway in this case.

1.4 Methodology

The first meeting of this DHR Panel was on 26th June 2013 with further meetings on 14th August, 16th October and 19th November 2013.

Prior to requesting IMRs the Panel sought to identify agencies that might have had knowledge of either Mrs or Mr B. To achieve this, a request for information was circulated via the lead Council Officers in each authority area using contact lists drawn up from their respective Multi-Agency Risk Assessment Conference (MARAC).

Based on the responses to these requests for information, IMRs were requested from eight agencies. A report template and guidance on completion of the IMR drawn from the Home Office Guidance was provided to these agencies, all of whom supported either a full IMR or a proportionate summary of their involvement:

- Sussex Police
- Bedfordshire Police
- [redacted] District Council
- High Weald Lewes Havens NHS Clinical Commissioning Group (CCG)
- Sussex Partnership NHS Foundation Trust

- Luton CCG
- Luton Borough Council Children's Services
- Brighton & Hove Adult Social Care

During the course of the review, additional requests for information were made to both Police Forces (to supplement their original IMRs), to the CCG (to clarify issues in their IMR), as well as to the South East Coast Ambulance Service (SECAmb) and the Royal Sussex County Hospital (BSUH) in regard to possible contact with a former partner of Mr B's who attended A & E in June 2009.

The Panel Chair met with Mrs B's mother and employer, [redacted] and Mr B after his conviction. Information and perspectives gained in these meetings was shared with the Panel.

The Chair met Mrs B's mother in May 2013, but other meetings were not held until the conclusion of the criminal trial - which took place in July 2013. Gaining this intelligence, by meeting with the perpetrator and having access to individuals who were otherwise witnesses in the trial, has contributed significantly to the context and information incorporated into the report and recommendations. It has also meant that the report was completed outside the Home Office's guideline timeframe.

A copy of the Executive Summary and Overview Report were shared the mothers of Mrs and Mr B respectively. No feedback was provided by Mrs B's mother, and one request relating to a matter of fact was received from [redacted], leading to a minor amendment to the report.

1.5 DHR Panel

The Panel had an Independent Chair, who was commissioned by the Safe in the City Partnership and East Sussex Safer Communities Partnership. They were independent of all local agencies.

The Panel was made up of senior representatives from those agencies that had provided IMRs, as well as representatives from the Safe in the City Partnership, East Sussex Safer Communities Partnership and Brighton & Hove CCG. Specialist domestic abuse services participated on the Panel from Brighton & Hove (RISE) and East Sussex (CRI) ensuring that there was non statutory and independent representation.

In addition, IMRs were submitted by Bedfordshire Police and Luton CCG, with a chronology also being submitted by Luton Borough Council Children's Services.

Given the joint work being undertaken by Bedfordshire and Sussex Police in this review, and the minimal relevant contact between the other agencies with either Mrs B or Mr B, it was jointly agreed by Safe in the City Partnership, East Sussex Safer Communities Partnership and Luton Community Safety Partnerships that these agencies did not require direct representation on the Panel. However, throughout the process, there has however, been an ongoing exchange of information between the CSP areas to facilitate relevant enquiries as part of the review. Furthermore, at the conclusion of the review, the report and action plan have been shared with Luton CSP to consider the recommendations, in particular 1 and 2 which had a specific bearing on

the local area. It has subsequently been agreed that Luton CSP will oversee the implementation of these recommendations within its locality and that it will provide progress updates to the Safe in the City Partnership and East Sussex Safer Communities Partnership inform their monitoring and implementation of the overall action plan.

Panel membership was:

Nick Georgiou	Independent of all local agencies	Independent Chair
David Hills	Sussex Police	Review Officer
Douglas Sinclair	East Sussex County Council	Head of Children's Safeguarding
Dr Anne Miners	Brighton & Hove CCG	General Practitioner
Gail Gray	RISE	Chief Executive
James Rowlands	Brighton & Hove City Council	Violence against Women and Girls Strategy Manager & Commissioner
Jason Mahoney	East Sussex County Council	Joint Commissioner for Substance Misuse
Linda Beanlands	Brighton & Hove City Council	Community Safety Commissioner
Louisa Havers	East Sussex County Council	Head of Performance, Engagement & Safer Communities
Micky Richards	CRI	Deputy Director – Operations
Neil Waterhouse	Sussex Partnership NHS Foundation Trust	Service Director
Shaun Lewis[1]	Quality Clinical Manager	High Weald Lewes Havens CCG
Sharon Gardner-Blatch	High Weald Lewes Havens CCG	Head of Quality

Charlotte Farrell, Brighton & Hove City Council Partnership Support Officer facilitated the work of the Panel.

The Overview Report has been written by the Independent Chair in discussion with the Panel.

[1] The High Weald Lewes Havens CCG was represented throughout by Shaun Lewis, with additional representation from Sharon Gardner-Blatch at the start of the review process.

2 The Facts

2.1 This section has been informed by discussion with the respective families of Mrs B and of Mr B, Mrs B's employer and in talking with Mr B, in addition to the IMRs provided.

2.2 Mrs B and Mr B met in November 2010, and became engaged a month later at Christmas. Mr B then moved into Mrs B's family home in [redacted] in February 2011 where several other members of her extended family also lived.

2.3 They lived in [redacted] for some 6 months before moving to Mr B's [redacted] home in [redacted]. They married in September 2011.

2.4 It seems that Mr B became depressed and withdrawn in January 2012. This was a time of considerable loss: it followed a [redacted] in December 2011 / January 2012; also at this time Mr B learned of the death of his young daughter (with whom he had no contact). In addition, it was the [redacted] anniversary of the death of [redacted] and a friend of Mr B's had also died.

2.5 Mrs B successfully established herself in her work over the next year while Mr B remained largely in the house spending a good deal of his time playing an interactive computer game.

2.6 Increasingly in the autumn of 2012 the relationship was under strain. This came to a head on New Year's Day January 2013 when Mrs B said that the relationship was over and that she was looking to move out.

2.7 It then seems that there was a brief reconciliation when they looked unsuccessfully for somewhere to move to together, but they were unable to find anywhere they could afford. Shortly afterwards Mrs B said that she had a room that she was moving into on her own and that the relationship was over.

2.8 Over the next month or so there was contact between them in regard to Mrs B removing her belongings from the house in [redacted]. Indeed, on the 11th February two police officers were passing the house when there was an apparent dispute between Mrs B and Mr B in the street. This incident appears to have been related to Mrs B's attendance at the house with a friend to collect some of her possessions.

2.9 On the evening of Sunday 17th February Mrs B and Mr B had arranged to meet in a public place in Brighton in order for Mr B to give his wife some of her possessions. This was near to Mrs B's place of work. In the event, after an initial meeting in the late afternoon when she was given some computer parts, they arranged to meet again in the evening. At both these meetings Mrs B had asked a friend to be present, though from the friend's witness statement it does not appear that she had expected any violence from Mr B when they met. It was at the second meeting that Mrs B was killed by her husband.

2.10 Immediately prior to this meeting Mr B made a Facebook posting saying: *"Goodbye to all my friends and family"*. He also made references to his wife as

"the cheating, lying, unloyal whore who destroyed everything I love and believed in".

2.11 When she met Mr B, a work colleague of Mrs B was standing close by. He attempted to intervene when he saw Mr B attack her with a knife.

2.12 Mr B was carrying four knives at the time of his arrest at the scene. Mr B cut himself in the attack, apparently deliberately, with the stated intention of killing himself, having texted this intention to friends prior to the attack. The phone he used was not his but his [redacted] and so, despite attempts, friends were unable to contact him.

2.13 The police were called by members of the public and were quickly on the scene where they apprehended Mr B. The Ambulance service was also on the scene quickly but Mrs B was declared dead in hospital at 10 pm that same evening.

2.14 Mr B was charged and found guilty of murder on 26th July 2013 and sentenced to 25 years imprisonment. He had pleaded not guilty to murder but guilty to manslaughter on the grounds of diminished responsibility.

2.15 Set out below is a history and chronology of contact with different agencies blocked into significant periods in their relationship and engagement with services.

Chronological information in relation to engagement with services
The focus of this section is on Mr B primarily. There is information relating to Mrs B before she met him but it is minimal and is not directly relevant to the remit of the DHR.

Mr B prior to 2011:

2.16 [redacted]

2.17 Mr B attended schools in Brighton and in [redacted], leaving at 16. For a short time he attended a college in [redacted] before returning home. It is understood that he experienced bullying at school as a teenager. Separately to school, [redacted]

2.18 [redacted]. No further information is available in relation to this incident which occurred in

2002. It is also unknown if a notification was sent to the local Children's Services at that time as there are no remaining records available.

2.19 It is understood that Mr B had various relationships with a number of young women, the details of which are not known, and the focus in this report is on those which appear to be of greatest significance only. He had a relationship with a woman who lived in London with whom he had a baby daughter in 2008. This is the daughter who he learned had died in January 2012. It is understood that this was a difficult relationship, the couple did not live together and there were extensive periods when there was no contact with mother or child.

2.20 Mr B also had a relationship with another woman starting in 2008 who moved into the family home in 2009 (Ms C). Ms C contacted the Police in response to media coverage of the death of Mrs B and provided a statement in relation to her previous relationship with Mr B in which she reported abusive behaviour towards her and cruelty towards her pet cat and rabbits. Mr B was very definite when spoken with that he had not been abusive towards Ms C, although he did acknowledge that he had broken a glass in frustration with her on one occasion, and that he had accidentally caused the death of a rabbit when he got up suddenly and it fell and hit its head on a table. However, he insisted that he had not abused Ms C and would not deliberately harm an animal.

2.21 Mr B was referred to the Mental Health in Primary Care Service in November 2009 by his GP. Mr B described this as a very positive engagement lasting some six months with sessions every fortnight or so. No records in regard to this have emerged in the IMR process.

Mrs B prior to 2011:

2.22 It does not seem that there was direct contact by statutory services with Mrs B prior to 2011 although there were child protection concerns in relation to her half-sibling who also lived in the family home in 2009.

2011

2.23 There was contact with Bedfordshire Police in April 2011 in what is described in the IMR as a "minor domestic incident" in April 2011. The circumstance of this was that the police received a 999 call from Mr B at the Luton address at 04.50 hours on Saturday 30th April 2011. He reported that he was restraining Mrs B - then referred to as his girlfriend - as she was hitting him and he did not want to hurt her. Officers were deployed immediately and arrived at the house at 04.58. Meanwhile the phone line was kept open and a struggle could be heard which indicated that there was physical and verbal aggression between them, e.g. the phone line picked up Mr B saying "If I get off will you keep hitting me?" and Mrs B shouting at him to leave.

2.24 The police record shows that they were with the couple for 17 minutes before they were redeployed to a 'High Priority Incident' in the town centre where a couple was being attacked by several men. An 'Incident Log' was opened in response to the emergency telephone call; this was subsequently closed and marked as a "verbal only domestic". Mr B was identified as being the aggrieved

party. A 'Domestic Incident Crime Report' was completed, although here Mrs B was identified as being the aggrieved party. A 'SPECSS[2] risk assessment' was completed in line with Force Policy.

2.25 In line with normal practice the incident was reviewed by a member of the Public Protection Support team later that day, with the paper work for a 'Domestic Abuse Incident' completed at 12.45 pm. Due to the SPECSS risk assessment scoring no points and no offences being revealed, the risk was assessed as 'standard'. It was concluded that there was no further role for the Domestic Abuse Investigation Unit.

2.26 The IDVA service in Bedfordshire was run by Victim Support in 2011. Victim Support would not have received a referral from Bedfordshire Police, given this was recorded by the Police as an incident rather than a crime.

2.27 The only other contact with services in 2011 was when Mrs B registered with a GPs practice in late December 2011 after moving to [redacted] in September 2011. Mr B was with her and sat in on the consultation. [redacted]

2012

2.28 On 11th January 2012 Mrs B attended the [redacted] Mrs B did not see the GP again after her discharge from the [redacted].

2.29 On 13th January [redacted] Council's Housing Advice [redacted] details of both [redacted] and Mrs B, identifying them as living within the household together [redacted] However, there was no discussion relating to Mr and Mrs B's personal circumstances.

2.30 Although not in contact with services at this time it is of note that Mr B learned of the death of his daughter on the 13th January, two days after her death, from a mutual acquaintance of his (as he and the girl's mother were not in contact). This was also the [redacted] anniversary of his [redacted] death, and Mr B says that a friend of his had also died at about that time.

2.31 [redacted] made contact with the GP practice on 3rd May because of her concern about [redacted], who is described in the GP notes from this phone call as *"...not been talking. He has been keeping to himself since the death of his daughter (from a previous relationship). Was working in a temp job. Has not been able to work since, not sleeping. Says he saw a counselor in the past and*

[2] Separation, Pregnancy/New birth, Escalation, Cultural Awareness / Isolation, Stalking and Sexual assault.

it helped him as he got on well with her. Was wondering if this was possible again. Encouraged to make appointment with GP's surgery."

2.32 Mr B saw the GP that same day when he also spoke about his wife's [redacted] and the anniversary of [redacted] death ([redacted]). The Patient Health Questionnaire (PHQ9), used as a depression screening form, scored Mr B at 16, which is equivalent to moderately severe depression. Mr B was encouraged by the GP to contact CRUSE Bereavement Counseling Service.

2.33 Mr B saw the GP on the 11th May when he was described as *"experiencing low mood. Poor sleeping, dizzy but not feeling suicidal".* A faxed referral to Health in Mind was made and a blood test arranged to rule out an underlining organic cause.

2.34 The following week on 23rd May, when he again saw the GP, he was started on Citalopram, an antidepressant.

2.35 Mr B again saw the GP on 27th June when he condition was reviewed. The Citalopram dosage was increased, and Mr B reported that he had an interview coming up for warehouse work.

2.36 The next contact was on 10th September when Mr B phoned requesting a repeat prescription. A review was set for a month later.

2.37 Mr B and [redacted] both report that in August or September Mr B did see a counselor. Mr B understood this person to be a trainee counselor who could only see him the once and that this would not be part of a longer term engagement of the type he had found very helpful in 2009. No reference has been made to this in any of the IMRs and the only record is Mr B's self report and his [redacted] comments. As reported, this trainee counselor offered one further session. As this was but an interim arrangement Mr B declined to take this up.

2.38 Mr B attended the surgery next on 17th October when there was further consideration of his depressed state. It is also recorded that he did not want Talking Therapy and that transport would be a problem in getting to the Health in Mind counseling service. It is probable that this is a reference to Mr B declining the further single session offered by the trainee counselor, but there are no formal records in relation to this.

2.39 The next contact was on 21st December when Mr B attended the GP surgery. It is recorded that he *"had had a job for a few weeks but not functioning so they had to let him go. Sleeping poor. Not functioning properly. Mood variable. No suicidal ideation. Citalopram increased to 30mg."* A second referral was made to Health in Mind and the PHQ9 score was given as 10.

2.40 There was no further contact during 2012.

2013

2.41 On the 4th January the referral to Health in Mind was considered and the case was passed onto the Psychological Wellbeing Practitioner for engagement with Mr B. He was written to on the 10th January by Health in Mind.

2.42 There is reference in the reports prepared by the psychiatrists for both the Crown Prosecution Service and the Defence in relation to the criminal process that Mr B contacted the primary care Out Of Hours service on the 19th January 2013. However, there is no reference to this in the CCG IMR and no such contact was reported to the GP by Mr B when he saw her two days later.

2.43 Mrs B attended the GP's surgery with Mr B on the 21st January 2013 about Mr B's condition. The GP spoke with Mrs B about her husband's sleep pattern. Her responses are not recorded and there is no reference to any concerns about her safety or home situation. Mr B wanted to reduce his antidepressant, and there was consideration of starting a different medication that might also help with his insomnia. The GP also requested that he respond to Health in Mind who had written to him on 10th January to arrange an appointment. Mr B was also given a leaflet intended for children giving advice to achieve an improved sleeping pattern.

2.44 On the 4th February Mr B saw the GP accompanied by [redacted]. Mr B was in a low mood with his [redacted] describing him as *"very low, withdrawn, not eating or sleeping"*. The notes indicate that he spoke about the loss of his daughter. His antidepressant was changed to Mirtazapine, which was intended to help him sleep better. No suicidal thoughts were recorded.

2.45 On the 11th February there is a police report showing that on a routine foot patrol outside the family home shortly after 8 pm there was a group of people talking together with one of the police officers hearing one of the men saying "Why won't you just talk to me". The group was made up of Mr B, [redacted] and a friend of [redacted] and Mrs B and a friend of hers. The officers asked if everything was OK and [redacted] explained that the couple was splitting up as it had recently been discovered that she (Mrs B) was having an affair. Mr B was tearful, and Mrs B was described as looking uncomfortable. She and the friend then left in a car.

2.46 The report of this incident indicates that the mood of the group was calm and there was not any suggestion that the situation would escalate. The officers suggested to Mr B that if he ever needed to talk he could go to the nearby Police Station and they would try to help him find a suitable support service such as Relate. This was an informal contact and no names were taken by the police officers of those involved.

2.47 On the 14th February the GP wrote to Mr B advising him of their contact with Health in Mind and that he should contact them.

2.48 Mr B has stated that he had initially intended to meet with Mrs B on the Saturday 16th but it appears that he fell asleep and did not meet with his wife as previously arranged.

2.49 On Sunday evening 17th February 2013 Mrs B was fatally stabbed outside her place of work in Brighton by her husband Mr B. Earlier that day, it is understood that Mr B returned to home after going out to meet his wife to collect the knives found on him when arrested. He also posted his goodbye message and the derogatory remarks about his wife on Facebook and texted his friends on the phone that could not be traced at the time.

2.50 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.

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

Voice of the Victim

2.52 Throughout this chronology the focus has been on setting out the engagement with statutory services by both Mrs B and Mr B with additional information incorporated from talking with those directly involved.

2.53 A significant challenge in undertaking the review was the limited information available to the Panel about Mrs B, and the absence of information from Mrs B herself. From talking with Mrs B's mother and employer there is a picture of Mrs B as a vivacious woman who was independent, applied herself well to her work, got on well and was well liked.

2.54 Mrs B's friend (who was with her at the time of the attack) was not interviewed by the Chair as it was felt that this could cause further distress at a time when we were given to understand he was still receiving support to cope with the incident (the rationale for this decision is described further in 3.8 below).

3 Analysis

The analysis of this tragic incident will draw on the chronology presented in section 2 above, the management IMRs provided by involved agencies, and information gained from the Chair's meetings with Mrs B's mother, with [redacted], with Mr B and with Mrs B's employer.

The analysis will focus in turn on the engagement of involved agencies, and then in how they worked together.

3.1 Contact with Bedfordshire Police

3.1.1 The only contact with Mrs B and Mr B where domestic abuse was a directly identified issue was with Bedfordshire Police in April 2011.

3.1.2 The IMR details the contact made by Mr B in a 999 call, the incident itself and the follow up. The Review Officer comments that:

"From the documentation available, this incident turned out to be a minor domestic situation and by the time the officers arrived there was no indication that it had developed into anything more serious than a verbal dispute. However the initial call received by Bedfordshire Police would seem to indicate that this was not a straightforward case. According to the 'crime report', the aggrieved party was recorded as being (Mrs B , then girlfriend not wife) whereas the incident log identifies the male party as being the aggrieved and the person responsible for calling the police."

3.1.3 The IMR comment continues:
"At 12.45 hours that day, (a police constable) from the Public Protection Support Team reviewed the incident checked for any background history and completed a Domestic Abuse Incident Report. Although the Domestic Incident Crime Report categorized (Mrs B) as being the complainant and (Mr B) as being the accused, no offences were revealed, and therefore it was considered not appropriate to send a follow-up letter to either individual.

Due to the SPECCS risk assessment[3] scoring no points, (the police constable) assessed the risk as 'Standard', and concluded there was no further role for the Domestic Abuse Investigation Unit / Child Abuse Investigation Unit (DAIU/CAIU) at this time".

3.1.4 In completing the IMR the Review Officer interviewed one of the officers who attended the house on this call and completed the 'Domestic Incident Crime Report'; they also completed the 'SPECCS risk assessment form' in line with Bedfordshire Police Force policy. However, the officer was unable to recall the incident so was unable to clarify the questions that arose about the nature of the call and the respective roles of Mrs B and Mr B. This is commented on in the Effective Practice/Lessons Learned section of the IMR as follows:

[3] Separation, Pregnancy, Escalation, Cultural Awareness, Stalking and Sexual Assault' (SPECSS) model of risk assessment.

"It is always difficult to predict the outcome of a relationship even with first-hand knowledge of the family dynamics. As far as Bedfordshire Police are concerned this one incident would not have given any cause to predict that homicide would be the eventual outcome. The incident referred to in this review would appear to have taken place when both parties were heavily intoxicated with alcohol, and there are no other incidents that came to the notice of the police to suggest that this behaviour was typical.

However, the unfortunate situation with the response officer... being unable to recall this event and the period of time the officers spent at the scene leaves the Review Officer concerned that possibly, more could have been done in this case. The comments on the crime report and domestic violence report do not rationalize either the initial call to the police or the background conversation overheard by the call taken. Although the DVIU officers (were) compliant with Force Policy, more time spent at the scene and a more enquiring mind may have identified a pattern of behavior unknown to the relevant agencies. This may have been a missed opportunity. The Review Officer fully accepts that the DVIU has only limited resources and their reliance on response officers acting effectively in the first instance is obvious. This ambiguity may easily be explained but should have been identified and clarified with further enquiries by DVIU staff."

Panel Comment

3.1.5 The Panel endorses the Review Officers comments. Follow up questions were also put to Bedfordshire Police in relation to:

- The duration of engagement by officers on the scene in April 2011 and why they were called away;
- The categorization of the incident as "verbal only" when it was evident that there was a degree of physical restraint;
- The differences between the call log and the officer's record;
- Whether the incident should have been referred to a specialist domestic abuse support agency; and
- If the change from SPECCS to DASH[4] risk assessment might lead to a different risk categorization?

3.1.6 Bedfordshire Police responded to all these questions. The Panel was satisfied with the explanation for the officers being redeployed as there was a serious 'High Priority Incident' taking place requiring more police presence in the town centre.

3.1.7 The incident was recorded as a "verbal only domestic", and the risk assessment as being 'standard risk'. This decision was questioned within the DHR Panel. There was consensus from representatives with a specialist domestic abuse background that while the information would not have necessarily meant that the case should have been graded as high risk, it did appear to indicate that the case should have been investigated further. In particular, this reflects the facts

[4] Domestic Abuse, Stalking and Honour Based Violence (DASH 2009) Risk Identification, Assessment and Management Model.

of the incident that were disclosed to the Force Control Room Operator (that Mr had restrained his partner by sitting on her; that Mrs B may have been attacking Mr B; and both had been drinking).

3.1.8 While there was a review of the case later that day, in line with normal procedure, a decision was made not to follow up. This decision was questioned by the Panel. While no crime had been reported, given that both parties were under the influence of alcohol, and officers were only on the scene for a short period of time, a follow up would have been appropriate. In addition, there is no indication that the parties were spoken to separately. The Panel felt this was particularly significant given the incident was left unresolved, including a lack of clarity as to the identification of the complainant.

3.1.9 Concerns were noted regarding the process of recording events/actions. It is recognised in the IMR quoted extensively above that the recording of the event was inconsistent, with differences between the original incident log and the subsequent crime report being unresolved. The lack of clarity as to the identification of the complainant (i.e. which party was the victim and which the perpetrator or indeed whether this was a situation where both Mrs B and Mr B were physically and verbally abusing each other) was not followed through. There is no indication that the parties were spoken to separately. It is unknown if the records were reconciled in discussion but there is no indication that this did happen on the available records.

3.1.10 It was noted that recording the incident differently could have caused a trigger point and therefore further investigation. However, the view given by Bedfordshire Police in response to the question about the different risk assessment processes of SPECCS and DASH indicated that on both measures this incident was regarded as 'Low risk'.

3.1.11 As noted in 2.26, there was no onward referral to a specialist domestic abuse service as this incident was not recorded as a crime. The Panel noted that this may have been a missed opportunity to offer support, although accepted that this reflects policy at the time and the referral of all incidents (in addition to crimes as is currently the case) would have resource implications.

3.1.12 Overall the Panel noted that there were a number of issues relating to the recording of the incident and these were unresolved; it is not clear if either party were spoken to separately at the time, nor was there any follow up in which they may have been spoken to subsequently; also, no referral was made to specialist agencies as this incident was not recorded as a crime.

3.1.13 Consideration of these issues leads to the following recommendation:

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.

3.1.14 This incident illustrates the complexity of identifying relatively minor situations that may occur often, but have the possibility of becoming, or indicating, something more serious. A parallel with medical practice was discussed in the Panel where the presenting symptoms might be relatively low level but could also be the early manifestation of a serious condition not immediately detectable. General Practice in medicine has a "safety-netting"' process whereby patients are advised when to seek further advice if their symptoms resolve or evolve

3.1.15 Drawing on this model of targeted advice provided at a time when people are most likely to be receptive, and therefore most likely to be take note and act on it. The Panel recommends:

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.

3.2 Sussex Police

3.2.1 There was some involvement with Mr B as a juvenile in 2002 when [redacted]

3.2.2 In January 2010 the police records show awareness of who was living in the family home at that time: [redacted] and [redacted], [redacted] and Mr B and his then girlfriend (it is not clear who this was).

3.2.3 There was contact in February 2013 (see 2.45 and 2.46) when a routine Neighbourhood Policing Team foot patrol came across the group of people including Mrs B and Mr B in a verbal dispute. The officers appeared to have a placating effect on the dispute and offered Mr B the opportunity to meet with local officers when he felt low. Mrs B had by then left the scene with the friend who was accompanying her.

3.2.4 The only other contact was at the time of the murder when the police responded promptly to the 999 call and apprehended Mr B.

Panel Comment

3.2.5 The Panel endorses the analysis of involvement by Sussex Police in their IMR, which identifies the engagement with Mr B in February 2013 (when he was spoken to as part of the group in [redacted]) was a positive example of

community policing. . The officers offered the opportunity to Mr B to speak with them further and advice (and possibly help) to contact Relate.

3.2.6 At the time of his arrest the police response is correctly described in the IMR as "prompt and effective", administering first aid to the victim prior to the paramedics attending, securing the crime scene, gaining the details of witnesses, arresting Mr B and ensuring that he received the necessary medical attention to the intentional injuries he had made to himself.

3.2.7 On a broader point relating to the IMR process, there was a degree of caution in sharing all relevant police information as the criminal trial was impending. The effect of this was that the Panel received information in a somewhat piecemeal manner, including a witness statement from a former partner of Mr B. This is a genuine dilemma when the two processes of the DHR and the criminal trial converge that will affect a number of DHRs.

3.2.8 This DHR was a learning opportunity as it was the first DHR undertaken locally while a criminal process was imminent. Reflecting this, and learning in neighboring authorities, the pan Sussex Domestic Abuse Steering Group has established a DHR working group. It is proposed that this group develop a pan Sussex protocol to ensure that there is a consistent process across the higher tier local authorities and statutory and voluntary sector partners in order to share learning and good practice from across Sussex and nationally. Additionally, it is intended that this group will identify the parameters of what information can be shared (and when) in the context of an imminent or ongoing criminal trial.

The Panel recommends:

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.

3.3 [redacted] District Council

3.3.1 There was only one contact and this was in mid December 2012 when the Housing Advice Office received a call from [redacted] included Mrs B and Mr B as part of a broader description of [redacted] circumstances.

Panel Comment

3.3.2 There was no indication from the record of this contact that any concerns were expressed about [redacted] or Mrs B, and the only reference to them was in relation to the broader housing and financial pressure. The Panel takes the view that there was nothing of note that might have been identified in this contact.

3.4 High Weald Lewes Havens Clinical Commissioning Group, Sussex Partnership NHS Foundation Trust and Health in Mind (HiM)

These IMRs are being considered together as there is a connection between them in relation to the GP's engagement with Mr B and subsequent referral to HiM. HiM is provided by Sussex Partnership Trust, who are commissioned by the High Weald Lewes Havens Clinical Commissioning Group to provide mental health services in the area.

Both Mrs B and Mr B were registered with, and seen by, the same Primary Care practice.

3.4.1 **In relation to Mrs B:** Mrs B attended the practice once [redacted]. She also accompanied Mr B in January 2013 when he saw the GP in relation to his insomnia and irritability.

3.4.2 When Mrs B saw the GP in December 2011 this was also her registration with the practice, so she was previously unknown to them. The IMR notes that on neither occasion did the GP note any concerns relating to Mrs B's home situation or safety. The IMR also notes that the practice received her medical notes from her previous practice in Luton on 2nd February 2012, and these were subsequently entered onto the electronic records system at the practice on 30th March 2012.

Panel Comment

3.4.3 The GP made a narrative entry onto the electronic system. It is not possible to confirm if this was based on a New Patient Questionnaire, which may have been completed in line with normal procedure. If this is the case, there would have been an original paper form that was shredded once the electronic entry had been made.

3.4.4 There is no evidence to indicate that Mrs B made any disclosures in relation to domestic abuse.

3.4.5 In regard to Mrs B's [redacted] This was her only consultation with the GP.

3.4.6 [redacted] A Discharge Summary to the GP was made and she was advised to follow up with the GP if she had further symptoms. The IMR states that:
"There appears to be no signposting on from ([redacted]) as to whether leaflets or support services are available should people require them. The (GP) practice manager gave assurances that when [redacted] this was done (provision of information) but since they moved into another practice there were 'gaps' in the service for follow up." The IMR says that this is being *"looked into as part of (the) action plan"* from this IMR.

3.4.7 Although there is no evidence that Mrs B made any disclosures of domestic abuse to either her GP or the [redacted], the Panel was mindful of the importance of ensuring that health practitioners are aware of domestic abuse. In particular the panel felt that it was important that professionals are aware of the range of health impacts and therefore potential clinical indicators that they may encounter in their practice, so that they are in a position to routinely consider the possibility of domestic abuse. The Panel recommends:

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[5].

3.4.8 **In relation to Mr B:** The CCG IMR documents Mr B's engagement with the GP practice:
"(Mr B) visited the GP practice on more than 8 occasions in the time frame given for this IMR. He was experiencing low mood. During these visits there was no recorded indication of any violence issues. He was described as withdrawn. The practice GP's did assess (him) using tools such as the Depression Screening Form (PHQ9). (Mr B) had an initial scored of 16 then proceeded to score 13 (seven months later).

Antidepressants were prescribed and reviewed. There had been some improvement with his condition with medication alone. Bloods were taken for any underlying organic disorders. On one occasion this was acted upon (there was a deficiency in folic acid) medication was prescribed to alter this deficit. On two occasions the GP referred AM to Health in Mind (HiM) via a referral form... faxed to HiM (on 21 December 2012).

The mental health service responded to these referrals via a letter. Even the GP contacted (him) on one occasion via a letter for him to engage with the mental health service. In October of 2012 it was documented that he no longer wanted talking therapy indicating there would be a problem with transport.

3.4.9 It is helpful to factor in at this stage the **IMR supplied by the Sussex Partnership NHS Foundation Trust** (who provide the Health in Mind service). The IMR included information provided by HiM, including a copy of the referral fax.

3.4.10 This IMR describes Mr B's referral to HiM in November 2009 with the commentary noting that he *"had previously been referred to the Mental Health in Primary Care Service. He was invited to attend an assessment but had declined to attend".* From the IMR this would appear to be on 1st December 2009. He was subsequently recorded as a Did Not Attend referral, the GP was notified and the case closed.

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

3.4.11 However, Mr B and [redacted], describe a significant engagement with a counselling service from June 2009 to December 2009 which Mr B found helpful. There is no reference to this in either IMR.

3.4.12 The IMR records when Mr B saw the GP on 17th October 2012 he was "*not wanting Talking therapy*" and that "*transport would be a problem for him with HiM services*". There is however, no reference to the session that Mr B says he had with a trainee counselor. There is no reason to doubt that this session took place. It is probable, from the information given by Mr B to the Chair of the DHR, that Mr B did not want an isolated session of "talking therapy" (as he described the counselor as offering) but wanted a more substantial series of engagement similar to that he described as beneficial in 2009.

3.4.13 In December 2012 and January 2013 the HiM record confirms the faxed referral by the GP describing Mr B's clinical presentation as *"Low mood and insomnia for months. On Citalopram (medication) since May. Losing jobs because of drowsiness".* The referral contained the PHQ-9 assessment score of 10 and Generalised Axiety Disorder (GAD-7) assessment with a score of 8. Both these scores are relatively low and, in the words used in the IMR, *"identify the patient as being of a mild presentation, and further confirm low risk."*

3.4.14 HiM assessed this referral on 4th January 2013. The case was referred onto a Psychological Wellbeing Practitioner within the service who wrote to Mr B on 10th January 2013 saying that he had been referred by his GP and asking Mr B to make contact with them, and set out the various ways he could make contact. The letter made it clear that if HiM did not hear by the 31st January 2013 "*we will close your file to Health in Mind on this occasion*". The Chair understands [redacted] that there were some difficulties with postal delivery/opening of post in the household at that time.

3.4.15 There is a reference in the reports of both the psychiatrists who saw Mr B in relation to the criminal process that he made contact with the primary care 'Out Of Hours' service on the 19th January; this is presumed to be self reported by Mr B to them. However, there is no reference to this in the CCG IMR or in the GP's records from when Mr B saw the GP two days later. Mr B saw his GP during the month of January; this was the occasion that he was accompanied by Mrs B. The GP asked Mr B to respond to the HiM letter but he did not do so.

3.4.16 The GP next saw Mr B on 4th February when he was accompanied by his [redacted]. This is recorded as a "*long consultation*" in the CCG IMR when the focus was his low mood, the loss he had suffered with the death of his daughter a year previously, continuing sleep difficulties and irritability. Mr B[redacted] was *"very low, withdrawn, not eating or sleeping"*, and [redacted] difficulties between Mrs B and Mr B were also discussed. Mr B's medication was changed from Citalopram to Mirtazapine with the intention of improving his sleeping. The IMR states that there were "no suicidal thoughts" on this consultation.

3.4.17 There was no further contact after this date and the incident a few days later.

3.4.18 The CCG IMR identified three recommendations from their work on this IMR. They are:

"1) The CCG will review its service for young adults (18+) particularly those trying to cope with loss, bereavement and depression.

2) The CCG will look at the service specification of Health in Mind (HiM); the referral system, correspondence and engagement process.

3) The GP practice to review their leaflets on sleep hygiene to ensure they are age appropriate.

Additionally, the practice manager is looking into reviewing follow up for those patients being health screened post registration by the practice nurses. She is also looking at follow up for those having had a miscarriage and signposting them on. Trying to forge a closer relationship with the midwives now they are no longer on site."

3.4.19 There were no recommendations from the Partnership Trust in regard to the provision of Health in Mind.

Panel Comment

3.4.20 The Panel was very conscious of the difficulties there are in working with people with low mood who are reluctant or inconsistent in their engagement with services. This may have been exacerbated by Mr B's use of alcohol in the later part of 2012 when he acknowledged an unusually higher level of drinking than what was his normal (self-reported) unexceptional level of alcohol consumption. From reviewing the information in regard to Mr B's consumption of alcohol the level of consumption would not have merited specific action by way of a referral to an alcohol misuse service.

3.4.21 The Panel chair has had the advantage of talking with [redacted] Mr B to gain their perspectives on Mr B's state of mind and engagement with services. From discussion with Mr B's [redacted] and with him it does seem clear that Mr B did receive a counseling service in 2009 which he found positive and helpful.

3.4.22 There is no record of this in the IMR from the CCG, Partnership Trust or the HiM paperwork. Indeed to the contrary, the record in the IMR states that he did not attend when previously referred in November 2009. However, the Primary Care Practice did have its own counselors in 2009 and it seems probable that it was one of these counselors that engaged with Mr B in 2009. There is reference in the reports of the criminal process psychiatrists to "Anger Management" as being part of the focus of this psychological intervention. It seems that Mr B relates this reference to a specific argument he had with a former partner rather than a sustained difficulty with managing his feelings of anger.

3.4.23 As described to the Panel chair [redacted], Mr B was referred for counselling support in May 2012 and, after a wait, he was seen in August or September 2012. However he had not appreciated that, rather than the beginning of a block of appointments offering a period of counseling support, this was an assessment appointment only. As indicated above, there is no indication of this engagement in any of the IMRs, so it is not possible to verify the purpose or focus of the session. Apparently Mr B was very disappointed at this and it had a detrimental effect on his mood and he felt badly let down.

3.4.24 This may be an issue that other people experience too, meaning that they are unclear about the purpose of their appointment, which may affect their commitment to attending. There is merit in considering if the correspondence is sufficiently clear about both the process and the purpose of the appointment they are awaiting. This has to be balanced against a form of words that might become either too complex or off-putting for people awaiting such counseling.

The Panel makes the following recommendation:

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.

3.4.25 During discussion within the Panel questions were raised about the difficulties in securing service for people with relatively low level mental health needs who may also misuse alcohol and drugs to some level, and who may benefit from the availability of a psychological intervention.

3.4.26 While not making a recommendation in regard to this the Panel refers this issue onto the local CCGs for consideration on the basis of their service demand information for such support.

3.4.27 In relation to Mr B's former partner (Ms C), a request for information was made to SECAmb and BSUH. Both agencies were identified as having come into contact with Ms C after she self injured following an argument with Mr B in June 2009. However, there was no record of contact with this previous partner in South East Coast Ambulance Service records. This is likely to relate to the record showing the call address rather than the name of the person.

3.4.28 The Panel has taken the view not to pursue this as we have seen the record of the A & E engagement which shows what happened at the time, Ms C's own health circumstances, the severity of the argument with her partner (Mr B) and the actions Ms C was to progress the following day.

3.4.29 Although this specific incident in 2009 might have been further followed up, the Panel noted that at that time there was no Health Independent Domestic Violence Advisor service available. However, the incident does emphasize the

importance of staff in such a setting having a good awareness of the risk of domestic abuse and of the steps to take should they have concerns.

The Panel makes the following recommendation:

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

3.5 Luton NHS Clinical Commissioning Group

3.5.1 The Luton CCG prepared an IMR which showed that Mrs B had been registered with a GP surgery between 2007 and 2011. The IMR was unable to provide greater detail than this as her records had, appropriately, been sent via the Practitioner Services Unit to Sussex when she registered with the [redacted] practice.

3.5.2 A check was made with the local Out of Hours service records and Walk-In Centre but they contained no reference to her.

3.5.3 Mr B was not registered with any primary care services in the Luton area.

Panel Comment

3.5.4 The absence of information is understandable. The IMR did moot a recommendation in relation to the records of people who move away from the area: *"The main recommendation would be that primary care retain a copy of the patient records via the Practitioner Services Unit as an electronic copy for those patients who have left the local area so that a more accurate foot print is traceable as to who they were registered with and any encounters they had with general practice. "*

3.5.5 The Panel noted this recommendation but did not feel it was sufficiently competent to determine whether this was practicable or appropriate. The DHR panel therefore refers this issue onto the local CCGs for consideration.

3.6 Luton Borough Council Children's Services

3.6.1 This was an appropriately brief IMR derived from the Luton Borough Council Children Services Care First Electronic System which showed some child protection work with Mrs B's half sibling in 2009.

Panel Comment

3.6.2 This information supports the view of the DHR Chair when he visited Mrs B's family home that the house was very crowded and with people living there with a network of relationships.

3.7 Brighton & Hove Adult Social Care

3.7.1 There was no contact with either Mr or Mrs B by this service. [redacted]

3.8 Mrs B's employer

3.8.1 Mrs B was killed outside the premises of her employer, although there is no indication that this location was specifically chosen by Mr B for that reason. Mrs B was accompanied at the time by a work colleague. While no formal IMR was requested, the Chair of the Panel met with her employer. This was after the conclusions of the trial, as both the Regional Manager and Mrs B work colleague were called as witnesses. The meeting was with the Regional Manager and the Human Resources (HR) Manager, and the information gained from this meeting is described below. The Panel chose not to speak to the work colleague who was present with Mrs B at the time of her death, or to other employees. This was because, from the discussions with the employer, it was clear that this individual, and other employees, were still distressed and receiving ongoing support from the company. In addition, it appeared unlikely that they had any further information that was not already known to the Panel. The Chair therefore decided against further meetings on the basis that these may increase distress when there was little to gain.

3.8.2 Mrs B worked in a large organisation but within a team structure. She had a relatively small number of colleagues with whom she worked closely. Neither of the people interviewed knew her personally, but they had come to understand her situation after the event. There were no disclosures made to her employer in relation to domestic abuse. There were also no ongoing issues around Mrs B's employment that might have indicated, in hindsight, that there were concerns around domestic abuse (for example, unexplained absences, lack of concentration at work).

3.8.3 On the Monday after the event, as described by her employer, the organization took a number of actions to support staff. This included briefing staff within their teams, as well as offering access to counseling which the employer sourced independently of local provision. Over the following period of time, access was provided to further counseling where this was required; in particular ongoing support to the employee had been with her at the time of the attack. The regional manager was in dialogue with his national counterparts/managers during this period and the company closed earlier than usual given the impact on staff.

3.8.4 Although the company does not have a formal policy or procedure for dealing with such incidents it was clear that they were proactive in their response in offering collective and individual support to staff.

3.8.5 The Regional Manager particularly welcomed the discussions he had with the senior police officer who took time to talk through the importance of support within the organisation and the impact of incidents involving the loss of a member of staff on teams, including those who did not know her directly. However, the Regional Manager observed *"the individuals* [in contact with the employer, specifically the senior police officer] *were great but I didn't feel* [this support was] *anything else than those guys taking their own personal time to help".* This perception may be a reflection on the skill and style of the police officer, but it is worth the local police considering if the support offered was provided within a formal protocol or dependent on the actions of an individual.

3.8.6 There are some lessons to emerge from this locally, Specifically, following the incident, the employer was not aware of how to access any specific information on services locally. No contact was made by any Brighton & Hove or East Sussex based victim support agencies, or by the local authority Partnership Community Safety Team.

3.8.7 The HR Manager welcomed the suggestion that local information could be made available, tailored to the needs of employers.

The Panel makes the following recommendation:

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.

3.9 Meetings with Mrs B's family and with Mr B and, separately, with his [redacted]

3.9.1 The Chair has met with Mrs B's mother and her partner. They gave a helpful description of Mrs B, describing her independence, energy and initiative. Mrs B's mother had no inkling of the extent of the difficulty in the relationship at the time, and was unaware that they had broken up. Her partner said that Mr B had contacted him as he was looking for Mrs B and thought that she was in a new relationship and that Mr B pestered him with phone calls and texts asking where she was.

3.9.2 They said that the family knew nothing about any threats or had any concerns for her wellbeing or that she might suffer harm. They said that various friends had seen his messages posted on Facebook at the time immediately before the incident, but nobody could make contact with him because his phone contract had ceased and he had his [redacted] phone with him and nobody knew at the time.

3.9.3 [redacted] spoke at length about [redacted], his relationship with his wife and state of mind.

3.9.4 The chair met with Mr B at Lewes Prison. He spoke candidly about his past, the relationship with Mrs B, his state of mind and engagement with services.

3.9.5 The impressions, discussions and intelligence gained from these discussions has been incorporated into this report.

4 Agencies working together

4.1 In this case there was limited opportunity for agencies to work together as neither Mrs B nor Mr B was well known to the various statutory services. There had been the contact with Bedfordshire Police in April 2011, which we comment on, and where the existent policy at that time did not prompt contact with a specialist domestic abuse support service.

4.2 It was also the case that Mr B was known to his local primary care service and, from his self report (and that of his [redacted]), had engaged positively in a psychological intervention in 2009 which may have included an anger management component. However, as has been identified in this report, it is not possible to be definite about this as there is no reference to this engagement in the health agencies' IMRs.

4.3 It also seems, from Mr B's presumed self-report to the psychiatrists who saw him in relation to the criminal trial, that he may have been in contact with the local primary care Out Of Hours service on 19th January 2013.

4.4 In the Panel's view it is probable that both these contacts as reported by Mr B took place. It does not seem, certainly in this instance, that the health agencies' information capture and / or sharing of such information within the health system worked well. However, it is not possible to say whether or not this might have been material in this case.

4.5 A key feature of the coordinated community response to domestic abuse is an understanding of the dynamics of abuse, in particular risk factors. While the Police use DASH, the multi-agency version of this tool is the CAADA-DASH Risk Identification Checklist (RIC)[6]. With reference to these tools, the Panel considered the risk factors that were present, either as a result of direct contact with Mrs B and Mr B (i.e. they were known to practitioners at the time), or which were identifiable as a result of the review process itself (i.e. they were not known to practitioners at the time). It noted that the only point of contact at which a risk tool was used was in relation to Bedfordshire Police. This identified information in relation to risk (specifically that Mr B had restrained Mrs B by sitting on her; that Mrs B may have been attacking Mr B; both had been drinking (3.1.7)). The contact, and the recommendations arising from it, is analyzed in section 3.1.

4.6 The only other point at which a risk tool could have been used was during contact with Sussex Police, although as analyzed in section 3.2 above and section 5 below, the duration of this contact was short and would not have be expected to have led to a risk assessment based on the information available at the time.

[6] CAADA Domestic Abuse, Stalking and 'Honour'-based Violence (DASH) Risk Identification Checklist (RIC) http://www.caada.org.uk/marac/RIC_for_MARAC.html

4.7 The Panel did note other information that identified during the review process. Examples of the risks that were noted (with the first reference to these in the report identified in brackets) include:

- The disclosures made by Ms C, in which she reported abusive behavior and cruelty towards her pet cat and rabbits (although Mr B denied this to be the case) (2.20)
- Mr B's experience of depression
- The separation of Mrs B and Mr B in January 2013 (2.6), as well as contact post separation (2.45) and on the night of his fatal attack
- Mr B's statements prior to his fatal attack on Mrs B, including suicidal ideation and jealousy (2.10).
- Mr B's use of weapons, specifically knives (2.12).

5 Good Practice

5.1 The engagement of the Neighbourhood Policing Team with Mr B in February 2013, while brief, reinforces the importance of this policing approach.

5.2 The presence of these officers in the local community gave the opportunity for contact and understanding of the pressures of people living locally. The specific advice given appears to have both helped to calm the situation, and in respect of Mr B to have offered him the opportunity of further specific contact and referral to a relevant support service should he want to take up that offer.

5.3 The Panel also noted the more general point and referenced good proactive work by another Neighbourhood Policing Team in a recent Adult Safeguarding Serious Case Review in Brighton. The Panel is aware of the unique role that local neighbourhood police officers have within their patch with opportunities to identify, respond to and potentially prevent domestic violence crimes and incidents.

5.4 These contacts reinforce the importance of a local informed presence in the neighbourhood which enables officers to take appropriate action. The Panel want to emphasise their view of the value of Neighbourhood Policing Teams able to sustain their high level of awareness to enable them to identify the potential circumstances for the occurrence of domestic violence, the associated risks and to respond to such risks. This requires a continuation of relevant training and support to enhancing such knowledge and skills.

5.5 After the incident the actions of the Senior Investigating Officer with Mrs B's employers was a very good example of positive work with people affected by this killing and support to them in how they handled this event with their staff.

5.6 The time, advice and support given by the Senior Investigating Officer was greatly valued and presented a very positive profile of local policing at a time of great stress and concern to a local business and its staff.

6 Lessons Learnt

6.1 Lessons learnt from this case are limited because the engagement of this couple was itself limited with statutory services, and there was no contact with any specific domestic abuse agencies.

6.2 What does emerge is a situation where 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.

6.3 This points to the importance more generally of wider societal awareness and understanding of domestic abuse, and we therefore make the following recommendation.

The Panel makes the following recommendation:

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.

7 Conclusions and recommendations

7.1 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.

7.2 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.

7.3 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.

7.4 By sending the text message and the Facebook messages on the day of the incident there was awareness among Mr B's friends that he might cause himself harm; his antagonism towards his Mrs B was also evident in the Facebook message. However, despite the efforts of various friends he could not be contacted, and he would not have seen any of the numerous people sending in Facebook messages urging him not to do anything harmful at that time.

7.5 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[7].

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.

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

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.

Nick Georgiou
Independent Chair of DHR
21 November 2013

Appendix One – Notification from the Home Office

Home Office

Safeguarding & Vulnerable People Unit
2 Marsham Street
London
SW1P 4DF

T **020 7035 4848**
F **020 7035 4745**
www.homeoffice.gov.uk

Mr James Rowlands
Violence Against Women and Girls Commissioner
Partnership Community Safety Team
Brighton and Hove City Council
Room 419, 4th Floor
King's House
Grand Avenue
Hove
BN3 2LS

13 June 2014

Dear Mr Rowlands,

Thank you for submitting the Domestic Homicide Review (DHR) overview report for Brighton to the Home Office Quality Assurance (QA) Panel. The review was considered at the April Panel meeting.

The QA Panel would like to thank you for conducting this review and for providing them with the final overview report. In terms of the assessment of reports, the QA Panel judges them as either adequate or inadequate. It is clear that a lot of effort has gone into producing this report and I am pleased to tell you that it has been judged as adequate by the QA Panel.

However there were some issues that the Panel felt that the report might benefit from consideration of the following points prior to publication:

- Please clarify the independence of the Chair;
- Clarification is also needed on who decided to conduct a DHR, and when the decision was taken to conduct the DHR;
- Clarify if the family where shown the report before submission to the QA Panel;

- Include some more text to explore the dynamics of abuse in the report and expand on the risk factors;
- Amend the tone and language at paragraph 7.1 removing the word "blighted" which could be interpreted by some to set the wrong tone or seems to make the perpetrator's perspective more prominent in this report. Please reconsider the appropriateness of opening the report by thanking the perpetrator for his contribution to the report as opposed to thanking family members for their contribution to the report; and,
- Revisit the grammatical structure of the report and clarify any ambiguities.

The QA Panel have also noted that the Chair omitted to speak with the victim's work colleagues in this case (as well as the employer), and would like to remind you that in future DHR's the QA Panel would expect the Chair to do so, particularly when the report identifies that it has been .

The Panel does not need to see another version of the report, but we would ask you to include our letter when you publish the report.

Thank you.

Yours sincerely,

Christian Papaleontiou, Acting Chair of the Home Office Quality Assurance Panel
Head of the Interpersonal Violence Team, Safeguarding & Vulnerable People Unit