East Surrey Community
Safety Partnership

Reigate & Banstead
BOROUGH COUNCIL
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EXECUTIVE SUMMARY

of the

DOMESTIC HOMICIDE REVIEW

relating to the death of Mrs A

on behalf of:

EAST SURREY COMMUNITY SAFETY PARTNERSHIP

Report author: **Liz Borthwick**
Independent Chair

18 December 2015

PREFACE

The purpose of this review is to examine the circumstances surrounding the sudden unexpected death of Mrs A (the victim of the homicide) in the borough of Reigate and Banstead, Surrey and to identify the support offered by relevant agencies to Mrs A and to Mr A (the apparent offender) jointly and separately prior to their deaths in June 2015.

The review considered the issues identified in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (DHRs), issued under section 9(3) of the Domestic Violence, Crime and Victims Act (2004) and aims in particular to:

- establish what lessons are to be learned from the domestic homicide regarding how effectively local professionals and organisations work individually and together to safeguard victims;
- identify clearly what those lessons are, how and within what timescales they will be acted upon, 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 future domestic violence homicides wherever possible, through intra and inter agency working.

The DHR panel members wish to thank the family and friends who participated in the review. We understand what a difficult time this must be and offer our sincerest sympathies on their loss.

Timescale

The review began on 3 July 2015 and concluded on 18 December 2015, with submission to the Home Office on 21st December. The Home Office responded on 5th April 2016 proposing a number of changes. These have been incorporated into this document in relevant sections.

Confidentiality

Detailed findings of each review are confidential. Information is available only to participating officers / professionals and their line managers.

Dissemination

The Executive Summary and Recommendations have been redacted to ensure confidentiality and have been disseminated to the following groups:

- East Surrey Community Safety Partnership
- Reigate & Banstead Borough Council's Leader's Group
- Surrey Adult and Surrey Children Safeguarding Boards
- Surrey Community Safety Board
- The Office of Surrey Police & Crime Commissioner (OPCC)
- The agencies involved in the review
- The families of Mrs A and Mr A.

ES CSP DHR EXECUTIVE SUMMARY

Mrs A (Date of death: 15 June 2015)

1. INTRODUCTION

1.1 The Overview Report into the death of Mrs A in June 2015 was commissioned by the East Surrey Community Safety Partnership (ES CSP). This Executive Summary details the process, key findings and recommendations highlighted in that report.

1.2 The Independent Chair of the panel and report author is Liz Borthwick, who has no links with ES CSP or Reigate & Banstead Council, the area in which the incident happened. Liz is a former Assistant Chief Executive at Spelthorne Borough Council who has considerable expertise in Adult Social Care and Safeguarding, and has been involved in a number of safeguarding reviews.

2. THE REVIEW PROCESS

2.1 It is a statutory requirement for a Community Safety Partnership to investigate the circumstances leading to a murder within an intimate relationship where criteria laid down by the Home Office are met. This is known as a Domestic Homicide Review (DHR).

2.2 In this instance, the review focussed on the circumstances leading to the death of Mrs A on 15 June 2015, following a fatal gunshot wound to her head at the couple's home within the borough of Reigate and Banstead, Surrey. The apparent offender, Mr A, also died of a gunshot wound on the same day at this location and is presumed to have shot himself after shooting his wife. To date the inquest has not been completed but current information indicates that that no one else was involved in the incident.

2.3 East Surrey Community Safety Partnership is a merged statutory group covering the administrative areas of Reigate and Banstead, Tandridge and Mole Valley. The Chair at the time of the incident was the Chief Executive of Tandridge District Council who notified the Home Office of the commencement of the DHR on 10 July 2015. The delivery of the Review was then transferred to the lead officer of Reigate & Banstead Borough Council.

2.4 Following a briefing from Surrey Police, a preliminary meeting was held on 3 July 2015 which confirmed that the incident complied with the statutory requirements for a DHR.

2.5 An independent Chair was appointed and the first DHR panel meeting was convened on 21 September 2015 following exploratory research by the Independent Chair.

3. DHR PANEL TERMS OF REFERENCE

3.1 The following Terms of Reference were agreed:

The Domestic Homicide Review panel will:

i. Ensure the review is conducted according to best practice, with effective analysis and conclusions drawn from the information related to the case.

ii. Seek to establish whether the event could have been predicted and therefore avoided.

iii. Liaise closely with the Coroner's office throughout the process and ensure the DHR helps to inform the inquest.

iv. 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 support victims of domestic violence or those with a mental illness.

v. 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.

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

3.2 The focus of this DHR also considered:

- Whether there were any barriers experienced by Mrs A, the victim or her family / friends / colleagues in seeking support from professional service providers;
- Whether there were opportunities for professionals to routinely enquire as to any domestic abuse experienced by the victim or any mental health issues that should have been referred to specialist health professionals or domestic abuse support services that were missed;
- Whether there were opportunities for agency intervention or support regarding Mr A, the perpetrator, which were missed;
- Given the use of a licensed firearm in this case, whether the licensing of firearms relating to the deceased male was rigorous enough and could anything further have been done to reduce the risk of the incident occurring;
- Whether there was sufficient consideration of Domestic Abuse in elderly relationships.

- Identification of any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and/or services.
- Appropriate consideration to any equality and diversity issues that appear pertinent to the victim, perpetrator e.g. age, disability (including isolation due to hearing impairment), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.
- Consideration of any other information that is found to be relevant. Where information emerges that disciplinary action should be taken, this will follow separate internal agency procedures.

3.3 Agencies represented on the DHR panel were;

- Reigate and Banstead Borough Council
- Surrey County Council Adult Social Care
- Surrey Police Public Protection
- East Surrey Clinical Commissioning Group
- East Surrey Domestic Abuse Service.

Methodology:

3.4 The Chair requested proportionate Individual Management Reviews (IMRs) from those agencies identified by the DHR Panel as potentially having contact with Mrs and Mr A. The agencies were provided with a framework and guidance for the process including a chronological account of their contact with the victim and / or the alleged perpetrator covering a period of three years prior to their deaths.

3.5 In particular they were asked:

- To identify whether there were any barriers experienced by the victim or family / friends / colleagues in seeking support from professional service providers;
- Whether there were opportunities for professionals to routinely enquire as to any domestic abuse experienced by the victim or any mental health issues that should have been referred to specialist health professionals;
- Whether there were any opportunities to support the alleged perpetrator which were missed; and
- Given the use of a licenced firearm in this case, could anything have been done to reduce the risk of the incident occurring.

3.6 Seven agencies submitted IMRs or indicated that they had no knowledge or contact with Mrs A and / or Mr A.

3.7 The Independent Chair also engaged with a number of voluntary and statutory agencies providing services in the area, to gain an understanding of the support available to older people and especially those with potential mental health issues and their carers.

3.8 The review has been supplemented by a number of interviews / conversations by the Independent Chair, with friends and neighbours in an attempt to understand the personal backgrounds of Mrs A and Mr A and to identify if there had been any previous concerns about domestic violence. These interviews were especially important as Mrs A and Mr A had no children, had relatives living in a different part of the country and appear to have been very private people; gaining insight into their lives prior to the incident has been challenging.

Family Overview and the Voice of the Victim

3.9 The DHR Panel acknowledges that it was very difficult to source details about Mrs A's personal life in particular. Available information came predominantly from health agencies treating Mrs A and from Mr A's family and friends (Mrs A's cousin chose not to be involved in the review). The Chair of the panel tried without success to gain further information about Mrs A from golf associates and family. This lack of direct information should be borne in mind when drawing conclusions.

3.10 Mrs A and Mr A married over 40 years ago in Leicestershire. Following their marriage they moved down as a couple to Redhill. They had no children and Mrs A had no siblings, the closest relative being a cousin. Mrs A worked full time in the City until her retirement, where she invested money for charities. She enjoyed playing golf at a number of local clubs and also bridge. Mrs A had rheumatoid arthritis and medical feedback states that she was responding well to a change in medication before her death.

3.11 Mr A initially volunteered at a local gun club where he was an active member and then began working at a local farm which he continued to do until his death. Mr A had a sister and nieces living elsewhere in the country with whom he was in regular contact and who he visited twice yearly. He last visited his sister before Christmas 2014 and was reported to have looked well. He came from a farming family and learnt to shoot as a child. Friends of Mr A stated that he was very trustworthy, very well liked and a hard worker.

3.12 Mr A had a severe hearing impairment since childhood. He wore a hearing aid but found it difficult to use the phone, preferring instead to write to his relatives. It appears that sometimes his deafness made him feel isolated.

4. EVENTS LEADING TO THE DEATHS IN JUNE 2015

4.1 Mr A's sister stated that Mr A had flagged up his concerns about his wife's failing memory in a letter written in March 2015. Mr A kept a detailed diary, which was discovered after their deaths. The entries show that he became increasingly

concerned about Mrs A's memory loss and her erratic behaviour, which appeared to have escalated from May 2015 when his comments became progressively more desperate.

4.2 It appears from his diary extracts that Mr A was struggling both practically (in terms of washing bedding and flooring due to Mrs A's incontinence) and emotionally, exacerbated by his hearing impairment, and was not able to cope. It is unclear whether Mr A was offered any support but he clearly states in his diary that he was unaware of where or from whom to get help.

4.3 Mrs A had visited her GP about this issue in March 2015 who had referred Mrs A to the relevant service to be assessed but no diagnosis had been made at the time of death.

5. KEY ISSUES ARISING FROM THE REVIEW

5.1 There was no evidence to suggest that Mrs A had experienced domestic abuse during her marriage to Mr A prior to her death in June 2015, although the panel is mindful that this cannot be ruled out with full certainty.

5.2 The review identified a lack of opportunity for Mrs A to speak privately to a health professional in the last few months of her life as she was always accompanied to her appointments by Mr A. An individual conversation would have allowed Mrs A the opportunity to share any private anxieties she may have had, including if there had been any concerns about domestic abuse. An individual conversation with Mr A would have allowed him to flag up worries about Mrs A's more intimate problems such as incontinence and his increasing inability to cope.

5.3 The review has identified ways in which support, advice and practice could be improved by health services including GP practices, to ensure the "whole picture" of a person presenting with memory impairment is reviewed, including that of the carer. This is more pertinent when the people involved are older, are carers or have a disability, which are potential triggers of domestic abuse in older people.

5.4 Mr A was a registered firearms holder and was appropriately issued a licence in accordance with Surrey Police procedures. Officers attending the property were not informed that firearms were kept on the property and this has been acknowledged and addressed as a training issue.

5.5 Firearms licences are renewable every five years and there is currently no requirement for an interim assessment of any medical health changes of the license holder or those also living in the property. The review makes recommendations to address this, with a particular focus on mental health.

5.6 It is clear that the firearms renewal process was carried out appropriately**.** Since this report was originally drafted, new guidance has been issued (April 2016[1]) to ensure GPs 'flag' the records of patients' holding a firearm licence with the expectation that any medical changes of concern during the licence validity are reported to the police licensing officer. A new mandatory application form has been issued which includes permission to share medical information.

6. CONCLUSIONS AND RECOMMENDATIONS

6.1 The Review proposes that the trigger for the domestic homicide was Mr A's overwhelming feelings of inability to cope with the rapid onset of Mrs A's failing mental health. Mr A appeared not to have known how to access help and it is unclear whether Mr A's mental health was considered an issue by medical professionals.

6.2 Having reviewed the available evidence, timing and circumstances relating to Mrs A's death, the Domestic Homicide Review Panel considers that the death could not have been prevented.

6.3 However, the proactive offer of support to Mr A, even in advance of a formal diagnosis of Mrs A's condition may have reduced Mr A's feelings of desperation and helplessness.

7. CONSTRAINTS OF THE REVIEW

7.1 The review has been constrained to some extent by the limited information available to the panel about the victim, Mrs A. Mr A's family has provided much of the information and along with some limited information from health professionals, a picture of Mrs A has emerged of a private, independent, capable woman prior to 2015. The rapid deterioration of her mental health is only documented through Mr A's diary; the process of medical confirmation had been initiated but not yet confirmed; Mrs A was due an initial CT scan on the day her body was discovered.

7.2 The review has also been constrained by the limited involvement and information provided by the GP practice. Although it is understood that general practices are not mandated to participate in a domestic homicide review, the benefit of learning and trying to improve should be considered in the future.

[1] Home Office Guide on Firearms Licensing Law 2016

8. RECOMMENDATIONS

Recommendation One - Surrey Health and Wellbeing Board

1.1 To increase health professionals' awareness (especially GPs) of the Surrey Safeguarding Adults Board and Surrey Safeguarding Children Board Domestic Abuse priorities and especially those relating to older people. This should include identification of the main triggers for domestic abuse in older people; poor long-term relationships, a carer's inability to provide the level of care required and / or a carer with a mental or physical health problem who feels under stress with the caring relationship.

1.2 To increase awareness and encourage participation in the IMR and Domestic Abuse training for GPs provided by organisations such as local Safeguarding Boards.

1.3 To encourage all health and safeguarding professionals to undertake training on routine enquiry about domestic abuse in line with the NICE guidance "Domestic violence and abuse; how health service, social care and the organisations they work with can respond effectively" *(February 2014)*

Recommendation Two - NHS England, Surrey and Sussex Teams

2.1 To implement good practice guidelines for GPs on their participation in DHRs, including the requirement of The Care Act, section six which states that partners must co-operate and share information.

2.2 To reinforce that Primary Care including GP practices should participate in relevant DHR training as provided by organisations such as Surrey Safeguarding Adults Board.

Recommendation Three - Surrey Domestic Abuse Development Group

3.1 To reinforce that all professionals need to review the "whole" family situation, especially in older people, when changes in health needs could lead to increased risk of domestic abuse. This should include the needs of the carer, especially if the carer is an older person.

3.2 To remind all professionals to ensure that when a patient is accompanied by a carer, there should be the opportunity for separate individual consultations with each in order to provide the space to divulge any confidential issues including domestic abuse.

Recommendation Four - For all District, Borough and Surrey County Councils

4.1 In partnership with voluntary and faith groups, to continue to enhance further services for older people (including for carers and those with mental health concerns) and the provision of accessible information.

4.2 To expand the distribution of this information to a wider range of facilities frequented by older people e.g. golf clubs, bowls clubs, day centres etc.

Recommendation Five – East Surrey Community Safety Partnership

5.1 To recommend to the Home Office that it should implement recommendation 11 within the HMIC report "Target the Risk" which is as follows;

Immediately, and with a view to implementation within 18 months, the Home Office should ensure that the current proposals for the sharing of medical information between medical professionals and the police for the purpose of firearms licensing, allow the police effectively to discharge their duty to assess the medical suitability of an applicant for a Section 1 firearms or shotgun certificate.

Since this report was originally drafted, further guidance has been issued (Home Office Guide on Firearms Licensing Law 2016) which addresses many of the issues raised in this report, although concerns remain that at present, as there is no statutory duty for GPs to comply.

Recommendation Six – East Surrey Community Safety Partnership

6.1 To recommend to the Home Office that it considers reducing the period for a firearms licence renewal from five years to three years, particularly in older people, which will ensure a more frequent medical review report to the police.

8. INDIVIDUAL AGENCY ACTIONS AS IDENTIFIED WITHIN THE SUBMITTED IMRS

Surrey Police

(1) That the Force Control Room checks police systems for Firearm license holders within a household prior to police deployment. This will be reinforced in future training.

(2) That the Head of Contact Management should review the current technical issues with the GUCCI / Intergraph interface as soon as practicable, to ensure a quicker check for the Contact Centre that there is a registered firearms holder at an address.

(3) That if, during the security visit, the Licensing Enquiry Officer suspects either the firearms licence applicant or someone co-residing in the property, suffers from a mental health related illness this, should be reflected in the police letter to the applicant's GP requesting specific confirmation of suitability.

Surrey & Sussex Health Trust (SASH)

(4) That Safeguarding Training will be updated to include a focus on the overall wellbeing of a patient and to highlight exploration of any potential domestic abuse issues.

(5) That a review is carried out of how information is gathered, documented and shared with other health professionals in order to support the wider wellbeing of a patient especially in Outpatients.