Content warning: over 18s only

The following document contains material of a highly sensitive nature (including references to death, violence, and abuse) and may be upsetting for some individuals.

EXECUTIVE SUMMARY

of the

DOMESTIC HOMICIDE REVIEW

and

SERIOUS CASE REVIEW

relating to the death of Doris, the injury to Lee and the emotional wellbeing of Sam.

on behalf of:

EAST SURREY COMMUNITY SAFETY PARTNERSHIP
and
SURREY SAFEGUARDING CHILDREN BOARD

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Independent Chair

Report submitted to Home Office July 2019

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1. Introduction

This Executive Summary outlines the process and findings of a joint Domestic Homicide Review (DHR) and Serious Case Review (SCR) undertaken by East Surrey Community Safety Partnership and Surrey Safeguarding Children Board into the tragic killing of Doris, the injury to Lee and the emotional wellbeing of Sam. The review began July 2016 and concluded with submission to the Home Office in July 2019. The Home Office requested some alterations in March 2020.and that the report should be published in a fully anonymised format. Doris's family had hoped to use her own name but they respected the request of the Home Office. The family chose Doris as a pseudonym. This report reflects these changes

2. Incident One - Domestic Homicide

i. On 2 June 2016, a 999 call was made by Peter from the family home. He described a knife attack upon himself and his daughter Lee and identified the assailant as Doris. Peter explained that Doris was in the dining room and that he was safe in the bedroom with their two children Lee and Sam. Peter stated that Lee had a cut on her arm and that he had a cut on his hand and his head was bleeding. He did not mention that Doris had sustained significant injury.

ii. When the Police arrived at the house, they found Doris lying face down in a large pool of blood on the dining room floor. A Police officer turned Doris over and found a large incision across her throat.

iii. Peter, Lee and Sam were found upstairs in a bedroom. Peter was holding a sock to Lee's injury and was crying. Both children kept asking "Why would mummy hurt us?" Peter stated that he had been hit on the head twice with a knife.

iv. Police and an ambulance attended and Doris was confirmed to be deceased at the scene. Peter, Lee and Sam were taken to hospital accompanied by the Police.

v. Later that evening on 2 June 2016, Peter was arrested on suspicion of murder.

vi. Lee and Sam were taken into Police Protection at the hospital until a foster placement could be arranged. The Local Authority issued an application for a Care Order (Children Act 1989) and they were subsequently made the subject of an Interim Care Order.

vii. On 3 and 4 June 2016 Peter was interviewed under caution. Peter stated that on 2 June 2016 he had been out at work and had returned home at 17.30. Lee and Sam had been out with their maternal grandmother and arrived shortly after him. Doris was waiting outside the house in her car (Doris and Peter were living separately at the time but shared the care of the children).

viii. Later in the evening, Peter and Doris had an argument in the kitchen over Doris's poor relationship with Lee. Peter states that Lee came between them, at which point Doris picked up a knife and swung it at Lee, cutting her arm. He states he pushed Lee out of the room and that Doris then swung the knife at Peter resulting in two cuts to his head. Peter took the knife from Doris but stated she kept coming towards him and they grappled. During this he inflicted the fatal knife wound to Doris's neck.

ix. In early June 2016 Peter was charged with Doris's murder and pleaded self-defence. In May 2017, following lengthy Crown Court criminal proceedings, Peter was found Not Guilty of her murder.

3. Incident Two (Serious incident against a child)

i. In early April 2016 the Police received a distressed call from Lee who stated she had been assaulted by her mother, Doris. A Police unit was immediately deployed to the family home and Lee answered the door, clearly upset and crying. Lee stated that Doris had thrown her off her bed onto the floor and started punching her and kicking her.

ii. Doris was interviewed by the Police and admitted that she had hit Lee on the bottom for misbehaving. Peter was not at home as he was working. The Police contacted Peter and he also mentioned that Doris had assaulted him on several occasions since January 2016.

iii. Doris was arrested on the same day on suspicion of assault on Lee. She was Cautioned for smacking Lee's bottom and for Common Assault on Peter.

The panel would like to express its sincere condolences to the family and friends who have lost so much due to the very tragic events as outlined in this report.

4. Domestic Homicide Review

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.

5. Serious Case Review

Serious Case Reviews are commissioned by the Independent Chair of the Local Safeguarding Children Board where:

i. Abuse or neglect of a child is known or suspected; *and*
ii. Either (a) the child has died; or (b) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

The Strategic Case Review Group of the Surrey Safeguarding Children Board agreed that the case met the criteria for a proportionate Serious Case Review (SCR) in accordance with Working Together 2015 Statutory Guidance. The Independent Chair agreed a joint DHR / SCR process for this case.

6. Terms of Reference

Terms of Reference were agreed by the DHR / SCR Panel in December 2016 and were regularly reviewed and amended as further details of the incident emerged (see Appendix One).

7. Independence of Chair

The Chair and author of the review is Liz Borthwick, formerly Assistant Chief Executive at Spelthorne Borough Council. Liz has a wide range of expertise including Services for Vulnerable Adults and Children, housing and domestic violence. She has conducted partnership Domestic Homicide Reviews for the Home Office and has attended Home Office Independent Chair training for DHRs and further DHR Chair training with Advocacy after Fatal Domestic Abuse (AAFDA). Liz has also been involved with a number of SCRs. Liz has no connection with the local Borough or any of the agencies in this case.

Liz was supported in this review by Debbie Stitt as DHR / SCR Co-ordinator. Debbie has worked in Community Safety for many years and has a thorough understanding and knowledge of domestic abuse and the processes involved in DHRs. Debbie has attended Home Office training in the running and delivery of DHRs.

8. Parallel and related processes

i. ***Post mortem and Inquest***

An inquest was opened into the death of Doris in June 2016. The Consultant Forensic Pathologist found that Doris had sustained incised open wounds to both hands, a 13.5cm long deep incised injury to her throat that had severed her carotid artery and jugular vein and completely severed her windpipe and oesophagus, resulting in massive blood loss. Cause of death was given as 'incised wound to the neck".

Once Peter's verdict of 'Not Guilty of Murder' was received the inquest was not resumed and a final death certificate was issued.

ii. ***Serious Case Review***

The Surrey Safeguarding Children Board (SSCB) was represented on the panel from the outset, which was renamed the DHR / SCR Panel to reflect its joint responsibilities. Lee was nine years old at the time of the incident. Every attempt has been made to include the voice of Lee and also Sam within the process and discover any relevant learning. The Panel agreed that the Terms of Reference would include Doris, Lee and Sam.

iii. ***Criminal Trial***

There were two criminal trial hearings; the first was stopped after 4 days due to new evidence introduced by Peter. At the second, the jury found Peter not guilty of Doris's murder in May 2017.

iv. Family Court Fact Finding Hearing

An initial Fact Finding Hearing took place in the summer of 2017 as part of the proceedings within the Family Court. Peter appealed the Judge's findings as the judge stated in the report Peter had deliberately killed Doris and had not acted in self-defence which differed from the outcome of the criminal trial. The appeal was upheld leading to a further hearing with a different judge in April 2018

The new Judge concluded that:

- On 2nd June 2016, Peter had killed Doris by cutting her throat.
- That following the breakdown in the relationship of Peter and Doris between December 2015 and June 2016, both parents failed to protect their children from their numerous verbal and physical disputes.
- That Lee and Sam had suffered long lasting trauma resulting from their exposure to the acrimonious and violent relationship between Peter and Doris and the death of Doris.
- That Peter inappropriately involved the children, especially Lee, in the adult side of their relationship, asking her advice and encouraging her to take sides.

v. Care Proceedings

The children's Care Proceedings concluded in autumn 2018. A Special Guardianship Order was made in respect of both children with their paternal uncle and aunt, along with a Supervision Order to Surrey County Council for 12 months.

vi. Police Disciplinary Investigation

The Police referred their involvement in this incident to the Independent Office for Police Conduct (IOPC). The IOPC stated there was no case to answer and referred it back for a local internal investigation.

Surrey Police reviewed its involvement in the case through its Public Protection Standards Team (PPST) and PSD (Professional Standards Unit). The conclusion stated there was no individual misconduct; the issues identified should be addressed in the form of learning, especially in the issuing of simple Police Cautions for child abuse.

9. Methodology

The Chair requested proportionate Individual Management Reviews (IMRs) from those agencies identified by the DHR / SCR Panel as potentially having contact with Doris, Peter, Lee and Sam. 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 from February 2010 until January 2017.

In particular they were asked to feedback on the following:

- Awareness of the potential presence of coercive control and how this impacted on the behaviour of the victim and perpetrator.
- Consideration of any equality and diversity issues that appears pertinent to the victim or perpetrator

- Identification of any training or awareness-raising requirements required to ensure a greater knowledge and understanding of the impact of domestic abuse and availability of support services.
- Consideration of whether the child's welfare was promoted and protected through timely and effective assessment including risk assessment and the response to the needs identified. This includes application of thresholds, information sharing, use of assessment tools and timely intervention.

10. Contributors to the Review

The following agencies submitted IMRs detailing their contact with Doris, Peter, Lee and Sam.

- *Surrey Police*
- *Surrey County Council Children Services*
- *Surrey and Borders Partnership Foundation NHS Trust (SaBPT)*
- *Surrey and Sussex Healthcare NHS Trust (SASH)*
- *Children and Family Health Surrey (CFHS)*
- *Health (Surrey GPs)*
- *Lee's Primary School and Sam's Nursery*
- *Doris's Employer*

The IMRs were completed by senior staff that had no direct management involvement with the family or the incident.

The panel gave detailed consideration and professional challenge to the IMRs submitted by these agencies and the final documents have contributed significantly to this report.

The following agencies and voluntary groups were contacted and confirmed that they had no relevant engagement with the family:

- *Borough Council*
- *East Surrey Domestic Abuse Services (ESDAS)*
- *Surrey Youth Service*

i. The Independent Chair supplemented the IMR information with face to face meetings with the front-line police and social workers who had been directly involved with the family.

ii. The Independent Chair and Coordinator of the DHR / SCR attended the conclusion of Peter's trial.

iii. The Family Court Fact Finding reports were shared with the Independent Chair and the Panel.

The Independent Chair also engaged with a number of voluntary agencies providing services in the area to gain an understanding of the support available to families who are suffering relationship breakdown.

11. Panel Membership

The Panel consisted of senior representatives from the following agencies: See Appendix 2 for full list

- *Surrey Police*
- *Surrey Safeguarding Children Board*
- *Surrey County Council Children Services*
- *Surrey and Sussex Healthcare Trust*
- *Surrey-wide designated GP for Safeguarding Children*
- *Surrey and Borders NHS Foundation Trust*
- *East Surrey Domestic Abuse Service*
- *Lee's school*
- *Borough Council*
- *East Surrey Community Safety Partnership*
- *Independent DHR / SCR Chair*
- *DHR / SCR Coordinator*

12. Contact with family and friends

Doris's mother and sister were fully engaged throughout the DHR / SCR process. They met with the Independent Chair on a number of occasions and also attended two panel meetings to contribute and ask questions about the review.

Initially Peter chose not to participate in the review but engaged much later in the process and met with the Independent Chair. Peter's family stated that they did not want to be part of the review.

Doris's new partner John, friends and work colleagues also contributed to the review.

13. Summary of the case

The DHR / SCR Panel received extensive information from family, friends, agencies and parallel proceeding reports about Doris, Peter, Lee and Sam. The DHR/SCR panel utilised the SCIE model "Learning together"[1] to identify the key episodes (KPE) in the lives of Doris, Peter, Lee and Sam.

- ***KPE One: Early Family Relationships and health, including birth of their children***

Doris and Peter seemed to have a reasonable relationship according to the family in the early days of their marriage. Doris and Peter worked, with Doris being the main provider. Like many families, there were the stresses and strains of working full time and looking after the children although maternal and paternal grandparents helped. Both parents were delighted at having the children.

[1] www.scie.org.uk/children/learningtogether/

- ***KPE Two: Bullying and coercion of Doris by Peter and grooming of the children and professionals***

Family and friends reported that Doris disclosed she was experiencing controlling and undermining behaviour from Peter. Family and friends said they heard Peter making comments about Doris's weight and saying "she had let herself go".

- ***KPE Three: Separation / Breakdown of the family unit late 2015***

In 2015 Doris and Peter's relationship had begun to deteriorate. Doris met John at work and a relationship started which Peter discovered. He could not accept the breakdown in his relationship, which became toxic with both parents being physically and verbally aggressive to each other. Doris was also allegedly aggressive towards Lee. Evidence showed that Peter's behaviour was controlling and manipulative towards Doris.

- ***KPE Four: Wellbeing of Parents and Children January 2016***

The situation at home was increasingly difficult with Peter threatening to take his own life. Doris was so concerned about his mental health that she went to the police but stated that she was not concerned about her own or the children's wellbeing at present. Following this disclosure, a number of agencies became involved with the family, the police, Children's Services and a number of health agencies.

- ***KPE Five: Changes in Lee and Sam's behaviour March 2016***

The school became increasingly concerned about Lee and her descriptions of what was happening at home and the adult way she was phrasing them. This raised worries that Peter was grooming the children. It was apparent that Lee and Sam were witnessing domestic abuse in the home. There were also concerns that Peter was trying to groom the teaching professionals.

- ***KPE Six: Assault of Lee and Peter by Doris April 2016***

Lee phoned the police in a distressed state to report that Doris had allegedly physically assaulted her by dragging her out of bed as she was refusing to get up. Doris was arrested and interviewed. Doris admitted that she had smacked Lee and in the past had been physically abusive to Peter for which she received a caution.

- ***KPE Seven: Child arrangements / Coercion and Control of the Children April 2016***

Following Doris's caution, it was agreed by Children's Services (SCS) that Doris would not have *unsupervised* access to the children but there was no contact between SCS and Doris for over six weeks and as such Doris did not see the children at all during this time. Peter appeared to be influencing the children and the access arrangements for Doris. Doris sought support to try to control her feelings and anger but her life continued to be very stressful, rising early to travel to get the children up for school to enable Peter to go to work and then going to work herself.

- **KPE Eight: Death of parent / impact on children and agencies June 2016**

Following Doris's death, Lee, Sam and Peter were taken to hospital and initially placed under Police Protection and then into foster care. The first placement was terminated following a complaint from the children. They were moved to a second placement where they became very settled. At the Care Proceedings review late 2018, a Special Guardianship Order was made in respect of both children with their paternal uncle and aunt, along with a Supervision Order to Surrey County Council for 12 months.

The case had a significant impact on professionals who attended the death scene or who had worked closely with the family. This led to the resignation of two experienced professionals, one with PTSD. Both experienced vicarious trauma (a process of emotional change in professionals who support trauma survivors resulting from empathetic engagement with them.[2]

14. Key issues arising from the review

The review identified a number of possible key triggers which led to the tragic events in which Doris died and Lee was injured including;

i. *Domestic Abuse* including coercive and controlling behaviour and lack of understanding of a victim's behaviour, including the use of retaliatory violence.

ii. *Mental Health Issues* relating to Doris, Peter, Lee and Sam which could have indicated domestic abuse.

iii. *Lack of professional curiosity* around DA including coercive controlling and stalking behaviour.

iv. *Lack of understanding around the DASH risk assessment,* and how a small number of factors such as coercive control, stalking, separation, self-harm, and mental ill health can indicate a relationship is high risk regardless of the number of positive responses from the victim.

v. *Lack of understanding of family dynamics* during the breakdown of a family relationship e.g. some professionals thought that risks had been diminished as Doris had moved out of the home, research shows this is not the case and risk increases.

vi. *Lack of understanding by professionals of grooming behaviour*, especially relating to the children and key professionals involved.

vii. *Lack of communication between and within agencies* and the family especially relating to KPE Six e.g. no contact for over six weeks between agencies and the family which increased stress and anger for family members.

viii. *Lack of risk management* around the assessment of KPE Four and KPE Six. e.g. including risk around organisational change and the impact on families and children.

ix. *Lack of Professional listening skills to fully understand the voice of the child* within complex family relationships. e.g. understanding the reasons behind why Lee was saying what she did.

[2] Vicarious trauma is a process of change resulting from empathetic engagement with trauma survivors. Anyone who engages empathetically with survivors of traumatic incidents, torture, and material relating to their trauma, is potentially affected, including doctors and other health professionals. https://www.bma.org.uk/advice/work-life-support/your-wellbeing/vicarious-trauma

15. CONCLUSIONS

i. This review has highlighted the tragic cost of coercive control and domestic abuse resulting in Doris's death and the emotional and physical abuse suffered by the children. The incident has a wide and enduring impact upon families, friends, colleagues and professionals. Doris and Peter seemed to have a reasonable life together until late 2015, although Doris mentioned she had felt controlled for years. There was then a rapid deterioration in their relationship leading to separation and ultimately to the tragic death of Doris, the serious injury to Lee and the emotional harm to Lee and Sam.

ii. During the six months prior to Doris's death a number of agencies had contact with the family. It would appear that agencies did not link events to see a 'bigger picture' and did not review the needs of the whole family during a time of relationship break up and separation. This contributed to the lack of understanding around risk in domestic abuse and how escalation can be a key indicator of high likelihood of serious harm.

iii. In 2016 there appeared to be a general lack of understanding by many professionals (and the wider community) regarding the breadth of domestic abuse and all its iterations. The legislation around Coercive Control[3] is still in its infancy and it remains a slow process of raising awareness. This confusion perhaps explains why it is still primarily physical acts of violence that are focused upon in response to domestic abuse. There is much more information required locally and nationally about controlling and coercive behaviour so that communities and especially victims know how to identify such behaviours. This may be assisted by the highly publicised recent release from prison on bail of a female jailed for the murder of her husband following years of controlling coercive behaviour, and the permitting of a retrial[4].

Surrey Police has an excellent track record for prosecution of cases involving controlling and coercive behaviour. In 2018 Surrey Police were successful in securing the first 'victimless' conviction in the country based on evidence from the victim's interviews only.[5] More recently in February 2019, a Surrey Police investigation led to a second male being jailed for rape and coercive controlling behaviour [6]

Professionals need a common understanding and approach to DA including training.

iv. The Police DA Matters programme appears to provide an excellent model in supporting cultural change and providing staff with the relevant tools to support the

[3] The Serious Crime Act 2015 (section 76): https://www.gov.uk/government/publications/statutory-guidance-framework-controlling-or-coercive-behaviour-in-an-intimate-or-family-relationship
[4] https://www.bbc.co.uk/news/uk-england-47407204
[5] Victimless prosecution" for controlling and coercive behaviour February 2018 https://www.kingsleynapley.co.uk/insights/blogs/criminal-law-blog/prison-sentence-following-victimless-prosecution-for-controlling-and-coercive-behaviour
[6] http://www.mynewsdesk.com/uk/surrey-police/news/man-jailed-for-rape-and-controlling-or-coercive-behaviour-360421

community in the future. All professionals working with families and children need to be empowered within a culture that encourages further insight, discussion and support outside of their respective organisations in order to raise concerns. As an example Doris did say to the GP that she had had enough of being controlled by Peter. The GP at the time did not probe further as they may not have been fully conversant with coercive behaviour and as such would not have understood this as domestic abuse.

v. This review identifies that it is imperative for agencies to work together to provide a coordinated approach to supporting families through crisis. The relationship between Doris and Peter in the last six months of Doris's life was toxic. This had a profound effect on Doris, Peter and Lee and Sam. If professionals had worked together to provide information and support to the whole family, then the obvious stress that Doris was enduring may have been reduced, resulting in a better relationship with Lee.

vi. *Working together to Safeguard Children 2018*[7] identifies that everyone who works with children has a responsibility to keep them safe. No single practitioner can have a full picture of a child's needs and circumstances and, if children and families are to receive the right help at the right time, everyone who comes into contact with them has a role to play in identifying concerns, sharing information and taking prompt action.

vii. It is imperative that agencies work together to provide a coordinated approach to supporting families through crisis. The recommendations below are designed to build upon the changes that have already begun in some agencies across all professionals to a common level where domestic violence or abuse and its nature are addressed more comprehensively and with improved understanding of its dynamics. This includes an understanding of the heightened risk of separation, coercive control, stalking behaviour, domestic abuse and child abuse and the tools in order to support the whole family.

viii. This review has highlighted the wider issue that DA and child abuse has had on professionals attending the tragedy and supporting the family. Expert trauma support following such a terrible tragedy should be readily available to professionals.

ix. The recommendations below are designed to build upon the changes that have already begun within agencies especially Surrey Police and SCS. The emphasis is now on giving all professionals the understanding of the dynamics around separation, coercive control, stalking behaviour and domestic abuse and child abuse and the tools in order to support the whole family.

x. There has also been valuable post-review learning around the following;

- *Lee and Sam's memories of Doris*
- *Foster Care for Children following a tragedy*
- *Wellbeing Support for professionals across the investigation*

[7] Working Together to Safeguard Children: https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

- *Process of a joint DHR / SCR*
- *Benefits of a Surrey-wise Designated GP for Safeguarding Children*

16 LEARNING IDENTIFIED

A number of key areas of learning were identified in the Review, based around the following;

i. Professional practice,
ii. Training especially about controlling coercive behaviour , recognising victim / perpetrator behaviour, interpreting and understanding the voice of a child and the high risk of relationship break-up and domestic abuse.
iii. Support for professionals
iv. Assessment of risk, especially around change management in organisations.
v. *Local and national campaigns to highlight controlling coercive behaviour*

The below recommendations highlight ways in which support in these areas can be improved;

17. RECOMMENDATIONS

A. Professional Practice

i. Recommendation One

The School, in partnership with Surrey Local Safeguarding Partnership, to develop guidance on supporting children and families during the breakdown of a relationship or family tragedy, which will include appropriate communication tools for children to voice their concerns.

Ownership: The School and Surrey Local Safeguarding Partnership

ii. Recommendation Two

Surrey Children Families and Learning (SCFL) to ensure that social workers are following procedures in supporting a connected person (non-professional) for supervised meetings between an adult and a child.

Ownership: SCFL (Surrey Children Families and Learning)

iii. Recommendation Three

SCFL to ensure that social workers always involve health professionals in Section 47 investigations to ensure a complete analysis of the family issues in order for appropriate support and resources.

Ownership: SCFL (Surrey Children Families and Learning)

B. Training - Local

iv. Recommendation Four

Agencies e.g. Police, SCFL, health and other agencies working with children to have the skills to understand the complexities of working with the voice of a child and in the use of the tools available to interpret what is being said in the context of the situation.
Ownership: Surrey Children's Services Academy

v. Recommendation Five

The Surrey Children's Services Academy, Surrey Safeguarding Children Board / Surrey Local Safeguarding Partnership and Surrey Safeguarding Adult Board ensure, through DA and safeguarding training, that staff working with families and children have an in-depth understanding of coercive controlling behaviour to include awareness of stalking, perpetrator grooming of family members and professionals, retaliatory violence and violent resistance**.**
Ownership: Surrey Children's Services Academy
Surrey Safeguarding Children Board
Surrey Local Safeguarding Partnership
Surrey Safeguarding Adult Board

vi. Recommendation Six

GPs to be reminded, through DA training, to evaluate the risk to other family members when engaging with a patient where there has been a disclosure from within the family. GPs should be familiar with the new GMC Guidance around information sharing and the need to record on patient records any decisions and the rationale behind decisions to share information outside of these parameters.
Ownership: Surrey Clinical Commissioning Groups (CCGs)

vii. Recommendation Seven

Surrey Domestic Abuse Management Board (DAMB) and borough Community Safety Teams to promote and recommend to local businesses and organisations that they join the Employers' Initiative on Domestic Abuse and introduce workplace domestic abuse policies to ensure that staff remain up to date and confident in their knowledge about DA and how to support employees.
Ownership: Surrey Domestic Abuse Management Board (DAMB)
Borough Community Safety Teams

C. Assessment of Risk

viii. Recommendation Eight

SCFL to ensure that social workers carry out a thorough assessment of need for children. This will include issues affecting the family e.g. breakdown of family relationships, separation, mental health, DA including controlling coercive behaviour.
Ownership: SCFL

ix. Recommendation Nine

SCFL / Surrey Children's Services Academy to ensure that all agency staff have support and management supervision including a robust induction programme into local procedures.

Ownership: SCFL / Surrey Children's Services Academy

D. Support for Professionals

x. Recommendation Ten

That the Police, SCFL, Education and Health ensure that they have sufficient clinical supervision (including trauma counselling) available on an ongoing basis to support staff who have been involved in a tragedy and if services are already available to ensure they are promoted to staff.

Ownership: DAMB

E. National and Regional

xi. Recommendation Eleven

That Surrey continues to support Home Office campaigns which reinforce public awareness of controlling and coercive behaviour including the behaviour of victims and perpetrators through public campaigns across different media.

Ownership: Home Office / DAMB

xii. Recommendation Twelve

Surrey DAMB to continue to reinforce public awareness of controlling coercive behaviour locally by campaigns in publications and public places.

Ownership: DAMB

F. National

xiii. Recommendation Thirteen

ES CSP to highlight the need for the Home Office and Ofsted to consider streamlining and guidance for joint DHR / SCR reviews.

Ownership: ES CSP

xiiii. Recommendation Fourteen

ES CSP to highlight to the Home Office the current underdevelopment of interpersonal violence interventions for relationships that are in the process of breaking down.

APPENDIX ONE

DOMESTIC HOMICIDE REVIEW
and SERIOUS CASE REVIEW PANEL
December 2016

TERMS OF REFERENCE

1. This Domestic Homicide Review (DHR) is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

2. This legislation places a statutory responsibility on organisations to securely share sensitive information, which will remain confidential until the panel agrees the level of detail required in the final report for publication.

3. A Serious Case Review (SCR) will run alongside this process to ensure full consideration of all factors leading to the death on 2 June 2016. As this will be both an SCR and a DHR, the Panel will seek to work jointly with this process to avoid duplication of contact with, or requests for information from, agencies, family members, friends and colleagues.

4. The DHR will strictly follow the East Surrey Community Safety Partnership (ES CSP) DHR protocol, which is based on Home Office guidance[8]

5. The statutory purpose of the DHR is to :

a) Establish what lessons can learned from the domestic homicide regarding how the local professionals and organisations worked individually and together to safeguard the victims of domestic abuse;
b) Identify clearly what those lessons are, both within and between agencies, how they will be acted on, and what will change as a result through a detailed Action Plan;
c) Apply these lessons to service responses including changes to policies and procedures as appropriate;
d) Prevent domestic homicides where possible in future through improved intra and inter-agency responses for all domestic abuse victims and their children.

6. The statutory purpose of the SCR is to:

a) Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children;

[8] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

b) Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result; and

c) Improve intra- and inter-agency working and better safeguard and promote the welfare of children

7. The agreed timeframe for information to be secured and reviewed is **five years prior to the event i.e. from May 2013**, unless there have been significant events identified before this.

8. The DHR will not seek to apportion blame to individuals or agencies from the information it receives. However, it is recognised that other parallel procedures (e.g. SCR, IOPC referral, internal agency disciplinaries) may use information from the DHR process to support their investigations.

9. The Panel notes that the DHR process may be suspended as necessary to avoid the risk of activities prejudicial to criminal proceedings. The trial is scheduled for December 2016. *(This was subsequently rescheduled to May 2 2017).* **The DHR will then recommence after the verdict has been issued.**

10. In addition the following areas will be addressed in the Individual Management Reviews (IMRs):

i. 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.

*ii. Awareness of the potential presence of **coercive control** and how this may have impacted on the behaviour of the victim and perpetrator. The Panel may invite input from experts in this field.*

iii. Consideration of any equality and diversity issues that appear pertinent to the victim or perpetrator[9]

iv. Agencies that had no contact will investigate whether helpful support could have been provided and if so why this was not accessed.

v. Consider whether agencies working with the family adopted a 'child- centred approach', viewing family conflict and incidents of domestic abuse through the eyes of the child.

vi. Consider whether the children's welfare was promoted and protected through timely and effective: assessment including risk assessment and response to the needs identified. (this includes application of thresholds, information sharing, use of assessment tools and timely intervention) and the recognition that risks do not reduce at times of parental separation.

vii. Consider whether there is evidence that managers and supervisors understood the experiences of children living with domestic abuse and the prevalence of the issue in the area.

[9] e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

11. The Panel will critically evaluate and approve the Overview Report, Executive Summary and Action Plan produced by the Independent Chair at the end of investigation prior to it being passed to the chair of ES CSP. If an SCR is completed, the Surrey Children's Safeguarding Board procedures will be followed.

APPENDIX TWO

DHR PANEL MEMBERS

ORGANISATION	ROLE	NAMED OFFICER
Surrey Police	Det Superintendent	Clinton Blackburn
	Force Domestic Abuse Advisor	Bridie Anderson
Surrey Safeguarding Children Board (SSCB)	SSCB Partnership Support Manager	Amanda Quincey
SCC Children's Services	Head of Safeguarding	Siobhan Burns Sam Bushby
Surrey and Sussex Healthcare Trust	Adult Safeguarding Lead	Fiona Crimmins
Surrey - wide GPs	Designated GP for Safeguarding Children	Dr Tara Jones
Surrey and Borders NHS Foundation Trust.	Safeguarding Adults & Domestic Abuse Lead	Debra Cole
East Surrey Domestic Abuse Services	Chief Executive	Michelle Blunsom Miatta Marke
Lee and Sam's school	Pastoral and Safeguarding Lead	Withheld to avoid identification of children
East Surrey Community Safety Partnership	Community Safety Manager	Hilary New Amanda Bird
Borough Council	Senior Manager for Leisure and Regulation	Ben Murray Justine Chatfield
	Community Safety Officer	Sarah Crosbie
	Independent DHR / SCR Chair	Liz Borthwick
	Independent DHR / SCR Coordinator	Debbie Stitt