Domestic Homicide Review

Executive Summary for David
May 2022

Final Version:

Parminder Sahota: Independent Chair and Author

Preface

The Independent Chair and Review Panel send their deepest condolences to all those impacted by David's untimely passing and thank them for their involvement and support in this process.

The primary objective of a Domestic Homicide Review (DHR) is to permit the learning of lessons from the death of a person(s) in a relationship where domestic abuse was known to have occurred. Professionals must understand what transpired in each situation for these lessons to be thoroughly and effectively digested. What must be modified most to lessen the likelihood of such tragedies?

The chair thanks the panel and people who submitted chronologies and materials for their time and cooperation.

"Dad was the life and soul of the party; he was a great guy."

Contents

Section One – The Review Process

1.1 Introduction and agencies participating in the Review.

1.1.1 This summary describes the Central Bedfordshire Community Safety Partnership's steps to review the death of one of its residents. The death occurred in May 2022.

1.1.2 The following pseudonyms have been used in the review:

- The victim: David
- Daughter– Gemma
- Father – Thomas
- Alleged person causing harm - Sharon

1.1.3 David was fifty-five at his death; he sadly died by suicide at home.

1.1.4 On 28 June 2022, following the Multi-Agency Statutory Guidance for Domestic Homicide Reviews (2016), Central Bedfordshire Community Safety Partnership commissioned a domestic homicide review.

1.1.5 The independent chair was commissioned on 18 August 2022. Central Bedfordshire Community Safety Partnership approved the completed report on X.

1.1.6 The panel convened for the first time with the chair on 16 September 2022.

1.1.7 On 23 May 2023, the review panel's final feedback was received.

1.1.8 Due to the number of current reviews and the necessity to balance agency demand, the procedure took longer than the six-month deadline stated in the statutory guidance.

1.1.9 On 6 December 2022, the chair contacted Gemma and provided her with the details of Advocacy After Fatal Domestic Abuse. She provided background information on her father. Having received the coroner's report the day before, she felt unable to continue. We agreed to communicate later. After receiving no response, the chair sent Gemma a letter requesting contact within a given time frame. There was no contact received.

1.1.10 On 23 March 2023, the chair contacted Thomas, who had not had much contact with David and provided a summary of David's drug and alcohol concerns. He requested no further contact because he was too distraught over David's death.

1.1.11 The panel discussed contact with Sharon. Due to their knowledge of her contact with mental health services, we agreed that the mental health representative of the panel would review whether the communication is appropriate.

1.1.12 The panel learned that Sharon had relocated. Since there had been no contact with the agencies on the panel, we agreed not to make contact to reduce the possibility of harm.

1.1.13 The following agencies and independent individuals who had no direct contact with Emma or contributed to the review:

Name	Role	Organisation
Anna Bruce	Deputy Head of Service	Bedfordshire Probation Delivery Unit
Amy Thulbourne	Service Manager, Safeguarding & Quality Improvement	Central Bedfordshire Council
Craig Laws	Detective Chief Inspector	Bedfordshire Police
Claire Beet	Safeguarding Nurse Specialist	Bedfordshire Hospitals NHS Foundation Trust
Daryl Springer	Manager	East London Foundation Trust
Dinh Padicala	Associate Director for Adult Safeguarding & Domestic Abuse	East London Foundation Trust
Jayne Dingemans	Adult Safeguarding Lead	Bedford Hospital
Jenny Riddy	Detective Inspector Emerald Team	Bedfordshire Police
Jodie Tripcony	Safer Communities & Partnership Officer	Central Bedfordshire Council
Joy Leighton	Senior Operations Manager	Victim Support
Leire Agirre	Head of Quality Improvement and Adult Safeguarding	Central Bedfordshire Council
Lisa Scott	Safer Communities & Partnership Manager	Central Bedfordshire Council
Lucy Wilson	Adult Safeguarding Lead	Bedfordshire Hospital
Marie Gresswell	Adult Safeguarding Lead	Bedfordshire Police
Martin Witchard	Review Officer	Major Crime Team, Police
Nadean Marsh	Designated Safeguarding Nurse	Bedfordshire Luton & Milton Keynes Integrated Care Board

Nina Page	Team Manager, Domestic Abuse Service & MARAC Lead	Central Bedfordshire Council
Nina Wright	Deputy Director, Luton Mental Health & Well-Being Services	East London Foundation Trust
Rachel Clifford	Public Health Principal, Mental Health and Wellbeing	Public Health
Susan Childerhouse	Assistant Director Public Protection & Transport	Central Bedfordshire Council
Toni-Marie Doherty	Head of Safeguarding	Bedfordshire Hospitals NHS Foundation Trust

1.1.12 Parminder Sahota is an independent author with eleven years of experience in domestic abuse and safeguarding. Advocacy After Fatal Abuse provided the Domestic Homicide Review Chair training in 2021. She has worked as a mental health nurse in the NHS for over 20 years. She is a Director of Safeguarding, Prevent, and Domestic Abuse Lead for an NHS Trust.

1.1.12 Parminder Sahota is independent of all concerned agencies and had no prior contact with David's family, Sharon, or the Central Bedfordshire Community Safety Partnership. She is independent of the participating agencies.

1.2.1Purpose and Terms of Reference: Key Lines of Enquiry

1.2.1 The statutory guidance sets out the purpose of domestic homicides reviews to:

- Establish the facts that led to the death in May 2022 and whether any lessons can be learned from the case about how local professionals and agencies worked together to safeguard David.
- Establish what lessons will be learned from the death regarding how local professionals and organisations work individually and together to safeguard victims.
- Identify these lessons, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change.
- Apply these lessons to service responses, including changes to inform appropriate national and local policies and procedures.
- Prevent domestic violence and related deaths and improve service responses for all domestic violence and abuse victims by developing a coordinated multi-

agency approach to identify and respond to domestic abuse at the earliest opportunity.

- Contribute to a better understanding of the nature of domestic abuse.
- Highlight good practice.
- Ensure that David's voice is heard regarding his lived experiences and the impact of the domestic abuse on his mental health. Allowing his journey to be told and identifying the lessons that may be learnt.

1.2.2 The review's time frame covered April 2019 to May 2022. The panel agreed that this time frame accurately reflected the difficulties discovered during scoping and subsequent communication with agencies.

1.2.3 The panel agreed on which agencies must submit a chronology and individual management review per Section 9 of the Domestic Violence, Crime and Victims Act 2004 (Revised 2016).

1.2.4 The panel agreed on seventeen terms of reference for this case.

Section Two – Agency contact and information learnt from the Review.

2.1.1 David received input from the following agencies during the period under review:

1. Bedfordshire Hospital
2. Bedfordshire Police
3. East London Foundation NHS Trust
4. GP

2.1.2 The panel determined that David began his relationship with Sharon a few months prior to his death. The exact date is unknown, however. In February 2022, he was reported to the police as the alleged perpetrator of domestic abuse against Sharon. In April 2022, following reports of Sharon's alleged abuse of David, David referred to Sharon as his ex-partner to the police.

2.1.3 April 2019 marked David's first contact with mental health services. He was hospitalised for four weeks due to suicidal thoughts.

2.1.4 In August 2019, he reported to the hospital in Bedfordshire that he was sleeping rough and had no support following his discharge. He was referred to the community mental health team to support him with housing.

2.1.5 David's mother died in February 2021, and according to his father, this profoundly affected him; he told his cousin he wanted to end his life.

2.1.6 David was readmitted to the mental health unit in June 2021 and again in October 2021 for suicidal ideation.

2.1.7 In December of 2021, David was offered a home with one bedroom. In April 2022, David reportedly stayed at a friend's house to get some respite from Sharon, whom he reported was abusive towards him.

2.1.10 Evidence of Domestic Abuse

2.1.11 Between February and May 2022, the police reported nine domestic abuse incidents involving David and Sharon. David and Sharon reported receiving abuse from each other.

2.1.12 David and Sharon were each served with separate Domestic Violence Protection Orders[1]. Sharon was subject to the order at the time of David's death.

2.1.13 David reported being the victim of domestic abuse by his ex-partner Sharon ten days before his death. He requested a housing relocation because he felt uneasy in his home.

2.1.14 Five days before David died, he informed East London Foundation Trust that he was sofa surfing.

[1] https://www.gov.uk/government/publications/domestic-violence-protection-orders/domestic-violence-protection-notices-dvpns-and-domestic-violence-protection-orders-dvpos-guidance-sections-24-33-crime-and-security-act-2010

2.1.15 Three days prior to his death, a police report alleged that David was the perpetrator of abuse towards Sharon.

2.1.16 A care coordinator from the East London Foundation Trust visited David's home two days before his death. He claimed to be a victim of domestic violence and was terrified of staying at home. They discussed alternatives to staying with his daughter, and he declined.

2.1.17 On the day David passed away, his neighbour called the police because Sharon was at David's home banging on the door while David's dog was noted to be in a car. David had reported his dog as a protective factor due to his distress. The police did not respond to this call because they were already on another priority call.

2.1.8 A few hours later, the concerned neighbour called the police again. The neighbour had escorted David back to his home and discovered multiple pills in the kitchen. They had unsuccessfully attempted to contact David.

2.1.19 The police attended and sadly found David in his home deceased.

Section Three– Key Issues Arising from the Review

3.1.1 **Agencies' Response to Disclosures of Domestic Abuse**

3.1.2 David disclosed to the police and East London Foundation Trust that he had been the victim of domestic violence. Sharon was served a domestic violence protection order. However, there was no mention of assisting David in accessing domestic abuse services.

3.1.3 The East London Foundation Trust noted safeguarding concerns but did not refer to the Local Authority.

3.1.4 **Male Victims**

3.1.5 Gemma described her dad as a "manly man" and felt he would not disclose abuse to his family or friends.

3.1.6 **Bidirectional Abuse**

3.1.7 The police had reports of David and Sharon being perpetrators of domestic abuse towards each other.

3.1.8 **Mental Health and Domestic Abuse**

3.1.9 David was diagnosed with recurrent depression and had experienced suicidal ideation resulting in hospitalisations.

3.1.10 **Information Sharing**

3.1.11 Information was not shared with relevant entities. For instance, East London Foundation Trust identified safeguarding concerns that should have been referred to or discussed with the Local Authority.

3.1.12 Gemma stated she was not informed of the concerns on the day David died and that East London Foundation Trust knew she was David's support.

Section Four– Recommendations

Multi-Agency Recommendations

4.1.1 Recommendation One: Agencies' Response to Disclosures of Domestic Abuse

1.a The Central Bedfordshire Community Safety Partnership to receive assurance from partners concerning their inclusion of the NICE Quality Standard (QS116) in their service policies and procedures. Practitioners should be able to enquire about domestic abuse and respond to disclosures.

4.1.2 Recommendation Two: Male Victims and Bidirectional Abuse

2.a The Domestic Abuse Service and Workforce Development has facilitated public campaigns to identify and respond to domestic abuse. These should be ongoing and should continue to involve male survivors of domestic abuse.

2.b The Domestic Abuse Service and Workforce Development will review the Respect toolkit and incorporate its contents into its domestic abuse training and processes.

2.c The Domestic Abuse Service and Workforce Development to develop a partnership-based strategy for addressing bidirectional abuse.

2.d The Domestic Abuse Service and Workforce Development is tasked with developing resources to aid in the identification of bidirectional abuse and the availability of support for victims/survivors.

4.1.3 Recommendation Three: Mental Health and Domestic Abuse

3.a. The local suicide prevention strategy should address the correlation between domestic violence and suicide, as well as alcohol and suicide.

3. b. The partnership to improve awareness of the suicide timeframe.

4.1.4 Recommendation Four: Information Sharing

4.a Central Bedfordshire Community Safety Partnership to receive assurance from partners concerning how they support staff to understand when consent can be overruled and utilise the resource provided by the UK Caldicott Guardian.

Section Five– Conclusions

5.1 David was 55 and not in a relationship at the time of his death.

5.2 David had previously disclosed suicidal ideation and was seen by a mental health service two days prior to his death. He reported being a victim of domestic abuse by his ex-partner Sharon and desired relocation of housing as a result.

5.3 David's neighbour contacted the police and East London Foundation Trust on the morning/afternoon of the day he died, expressing concern for David's welfare following Sharon's unexpected and aggressive visit.

5.6 The suicide timeline of Jane Monkton Smith[2] was used to facilitate learning and highlight the potential for agency engagement.

1. **The perpetrator has a history of abuse.**
   The police knew of Sharon's prior interactions with the law and incidences of domestic abuse. However, David was unaware of his right to know under the domestic violence disclosure scheme.
2. **The Relationship starts quickly or intensely.**
   The documents indicate that David began his relationship with Sharon a few months before his death, although the exact date is unknown.
3. **There is a relationship dominated by control.**
   David declared to the police and ELFT that he was so terrified of Sharon that he desired to relocate.
4. **The victim starts to disclose as they become more distressed by abuse or violence.**
   David reported domestic abuse to the police, but his family was unaware of this.
5. **The victim seeks help from agencies like the Police, Mental Health Services, GPs, or Independent Domestic Violence Advocates.**
   Between February and May 2022, the police received nine reports of domestic abuse involving Sharon and David.
   David disclosed to his mental health team that he had a traumatic history of domestic abuse.
6. **The victim starts talking about ending their life as abuse and stalking are persistent and intense.**
   David was hospitalised after two suicide attempts. On the day of his death, he was reportedly distressed and afraid of Sharon.
7. **The victim says they feel completely trapped by the perpetrator and will never be free.**
   David stayed at a bed and breakfast because he feared returning home. On the day he died, Sharon allegedly banged on his front door, and he was distraught by this and the fact that she had his beloved dog.
8. **There is a suicide.**

[2] https://twitter.com/JMoncktonSmith/status/1495129374886174728

5.7 Due to Gemma's lack of communication and Thomas' request not to receive the reports, they will not be shared with the family. However, they will be shared if they request them in the future.

5.8 The lessons learned will be shared with the agencies engaged in the review.

The Central Bedfordshire Community Safety Partnership will disseminate the learning from the review and develop an action plan to address the recommendations.