Norfolk County Community Safety Partnership

# DOMESTIC VIOLENCE HOMICIDE REVIEW

# OVERVIEW REPORT

REPORT INTO THE DEATH OF:

Mrs A aged 44 years

Report produced by:

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Date Completed: 21 June 2013

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# 1 Introduction

1.1 This Review was commissioned by the Norfolk Community Safety Partnership following the homicide of a Norfolk resident in an incident which appeared to fulfil the criteria of Section 9 (3)(a) of the Domestic Violence, Crime & Victims Act 2004 namely, the violence appeared to be by a person with whom she had an intimate personal relationship. The Review Panel would like to express their condolences to the family members of those who died in this distressing incident. The Panel also wishes to thank all those who have contributed and assisted with this Review.

1.2 This Domestic Homicide Review has been conducted in accordance with statutory guidance[1] under Section 9 of the Domestic Violence, Crime and Victims Act 2004. The Review examines agency responses and the support given to the victim who was a resident of Norfolk prior to her death. The victim died as a result of being shot by her husband. He then shot himself. The review will consider agencies contact and involvement with the victim and the perpetrator covering the period from 2005 up to the victim's death.

1.3 The key purpose for undertaking Domestic Homicide Reviews (DHR) is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.4 **Timescales:**

1.5 The Norfolk Community Safety Partnership Chair called a meeting of partner agencies 12 days after the incident which led to the deaths and the decision was taken that the circumstances of the case met the requirements to undertake a Domestic Homicide Review. The Home Office were notified of this decision 4 days later. The Review was concluded on 21 June 2013. There were no criminal proceedings associated with this case as the perpetrator committed suicide. The Review was completed slightly over the time stated in statutory guidance.

1.6 **Confidentiality:**

1.7 The findings of this review were held as confidential during the Review process. Information was available only to participating officers/professionals and their line managers until the report was approved for publication by the Home Office Quality Assurance Group. The Home Office Quality Assurance Group letter of approval is attached at Appendix A.

1.8 Information discussed by the agencies representatives within the ambit of DHR Panel meetings, is strictly confidential and must not be disclosed to third parties without the agreement of Panel members.

1.9 To protect the identity of the victim, perpetrator, and family members the following anonymised terms have been used throughout this Review:

The victim: Mrs A, age 44 years at the time of her death.
The perpetrator: Mr B, age 58 years at the time of the offence.

[1] *Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews*. Home Office 2011.

1.10 Both Mrs A and Mr B were of white British ethnicity.

1.11 Dissemination

1.12 The following recipients have received copies of this report for learning within their organisations:

The Chair & Members of Norfolk Community Safety Partnership
The Head of Environmental Health, A Norfolk District Council
The Chief Constable, Norfolk Constabulary
Vulnerability and Partnerships Command, Norfolk Constabulary
The Head of Quality & Patient Safety, Norfolk Clinical Commissioning Group
Chief Officer Norfolk and Suffolk NHS Foundation Trust
Patient Safety & Complaints Lead, Norfolk and Suffolk NHS Foundation Trust
Leeway Domestic Violence & Abuse Service, Norfolk
Head of Community Safety, Norfolk County Council
The Independent Chair, Norfolk & Waveney CCG Cluster Clinical Quality & Patient Safety Committee
Mental Health & Learning Disability Lead Commissioning
Chief Officer NHS England & NHS Eastern Region
Director of Public Health
County Clinical Commissioning Groups
Police & Crime Commissioner
County Domestic Abuse Reduction Coordinator

1.13 Purpose and Terms of reference of the review

The purpose of the review is to:

- Establish the facts that led to the death of Mrs A and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard Mrs A.

- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.

- Establish whether the agencies or inter agency responses were appropriate leading up to and at the time of the incident which led to the deaths.

- Establish whether agencies have appropriate policies and procedures to respond to domestic abuse and to recommend any changes as a result of the review process.

- To seek to establish whether the events leading up to the fatal incident could have been predicted or prevented.

Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

Terms of Reference:

1. To review the events and associated actions that occurred from 2005 up to the date of the death of Mrs A. Agencies with relevant knowledge of the victim or her husband before this time are asked to provide a brief synopsis of their involvement.

Relevant knowledge would include such contacts as the Police; statutory and voluntary agencies contacted for support in connection with their relationship; mental ill-health.

2. To review the quality and scope of action/s and services provided by the agencies defined in Section 9 of the Act which had involvement with Mrs A and Mr B her husband and other individuals e.g. friends, extended family, or employers, as identified within the agencies' records, Individual Management Reviews (IMR) or other information sources as deemed appropriate by the Independent Chair of the DHR.

3. To examine the knowledge and training of staff involved in relation to the identification of indicators of domestic abuse and the use of appropriate risk assessment i.e. the DASH risk assessment checklist, agencies own specialist risk assessments, and knowledge and use of appropriate specialist domestic abuse services.

4. Examine the effectiveness of single and inter-agency communication and information sharing, both verbal and written.

5. To assess the extent to which agencies relevant policies and procedures were followed, and whether these are up to date and fit for purpose in assisting staff to practice effectively where domestic abuse is present.

6. The Police to examine whether procedures were followed, additional information sought from all Police data systems, and the shotgun certificate holder's GP response was received and appropriate to inform the decision to grant continuation of a shotgun certificate to the victim.

7. To involve the family, friends and if appropriate employers of Mrs A and Mr B. The overview report writer will be responsible for meeting with family, friends and employers to invite their contribution to the DHR.

## 1.14 Methodology

1.15 This Review has followed statutory guidance issued for the conduct of Domestic Homicide Reviews (DHR). A total of 16 agencies were contacted to check for any involvement with the parties concerned in this Review. There were 11 nil returns and 5 returns confirming involvement. Of the agencies confirming involvement with the victim or perpetrator all submitted a chronology of their contact except one. The one agency who did not contribute to the chronology formally was a service which only provided equipment to aid Mrs A following surgery. The Police involvement was brief, but they were asked to provide a report in relation to item 6 of the Terms of Reference. The Norfolk & Norwich Hospital provided a chronology only as their involvement was brief and details of the victim's contact with them was detailed in GP records and was covered in the Independent Management Review for this service by the NHS Norfolk and Waveney Commissioning Support Unit. The Mental Health Trust also submitted an Independent Management Review. The agencies chronologies were combined and a narrative chronology written by the Overview Report writer.

1.16 The two Independent Management Review authors were independent of any line management or case involvement. The authors held the positions of Head of Quality & Patient Safety and Safeguarding Lead in the Patient Safety Department in the two Health agencies submitting the Independent Management Reviews. Guided by the

terms of reference for the Review one Independent Management Review examined the actions and processes of the Mental Health services accessed by the victim, and one examined the General Practitioner services provided to both parties. These were the two agencies whose involvement with Mrs A and Mr B warranted an Independent Management Review. The decision to start the time under examination from 2005 was taken by the Panel as it was during this year that Mrs A appeared to start suffering from a lengthy period of depression which required long term medication.

1.17 A letter was sent to the Coroner for the area to inform him of the Review, and if time permitted the Coroner expressed a wish to consider this Review in his deliberations.

1.18 The author sent introductory letters and the appropriate Home Office DHR leaflet to family members, friends, and colleagues; twelve letters in all. The author has communicated with the victim's family members during the Review process and the terms of reference were shared with them at the start to ensure that there were no further issues they wished to have included, and a final draft of the report was shared with them. Contributions have been received both by face to face interview, email and Skype. A relative of the perpetrator contributed via interview and the terms of reference were shared with them. Two colleagues of the perpetrator were interviewed, one face to face and one by telephone. One friend of the couple, and a friend of the victim were interviewed one face to face and one by telephone. One of the victim's colleagues provided an answer to a question by email, but did not wish to be interviewed and there was no response to the other letters.

1.19 There is a statutory expectation that the agencies contributing to this Review will have regard for the statutory Guidance for the Conduct of DHRs[2], and the Secretary of State can direct their participation under Section 9(2) of the Act. However, this Review cannot issue a witness summons giving the legal power to direct an individual to attend for interview. As a consequence additional information which may have been available from colleagues or friends who have chosen not to contribute to the Review has not been obtained by the author.

1.20 Documents to which the author has had access include Police reports, Post Mortem report, and the Association of Chief Police Officers (ACPO) Domestic Incidents: Safeguarding after Police Action instructions. The author has also had access to the victim's handwritten diary notes from the time period of 2000 to 2012. A majority of the diary recordings were not contained in actual diaries, but were written on sheets of paper and were not necessarily in chronological order. Some years had little or no recording and some notes were not always dated. Only diary notes which are relevant to this Review are cited, and efforts have been made to corroborate recorded incidents where possible. It is unlikely that Mrs A ever intended that the diary notes would be read and the candid nature of some of the notes uphold this superstition. Therefore the author believes the notes represent Mrs A's real experiences and feelings at the time they were written.

1.21 The Independent Management Reviews (IMRs) authors had access to the victim's and the perpetrator's medical information. As both parties were deceased there were no issues around consent. During the writing of the IMRs the author responsible for reviewing General Practitioner services involvement had access to GP clinical notes and the electronic patient management system used at the GP practice, including letters and reports received by the GP from other agencies involved in the care of both Mrs A and Mr. B. Discussion took place with GP's involved in their care regarding entries made into clinical notes to establish clarity and understanding of intentions and actions. The

[2] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews S9(3) page 5

author of the Mental Health IMR could not interview Community Psychiatric Nurse 1 who saw the victim as they no longer worked for the organisation; therefore patient records only were able to be reviewed. For the Police report Firearms Officers involved in the issuing and renewal of the victim's shotgun certificate were interviewed. The author has also liaised directly with the Firearms Department Manager to clarify procedures and legislation. The chronological notes for the Police attendance at the only reported incident of domestic abuse were very detailed and reported Officer 1 and Officer 2's attendance and handling of the report. This report did not result in action as the victim denied that anything had happened at the time. Each IMR was agreed and signed off by a senior manager in their organisation.

1.22 The author is most grateful for the contribution of family members at what is undeniably a difficult time for them, and for the information provided by the friends and colleagues who did feel able to contribute. The author appreciates the help and support of the Review Panel members and IMR and report authors, especially as this Review has coincided with substantial reorganisation within Health agencies which has affected the roles and responsibilities of the IMR authors in particular.

1.23 **Contributors to the Review are:**

- Norfolk Police – chronology and report
- Norfolk & Suffolk NHS Foundation Trust for Mental Health Services – chronology and Independent Management Review
- Norfolk Clinical Commissioning Group for GP Service – chronology and Independent Management Review
- Norfolk & Norwich University Hospital - chronology

Family, friends and a colleague have also contributed information to the Review.

1.24 **The Review Panel Members are:**

Detective Sergeant Paul Brownsell – Norfolk Constabulary
Superintendent Julie Wvendth, Safeguarding, Norfolk Constabulary
Michael Lozano – Patient Safety & Complaints Lead, Norfolk & Suffolk NHS Foundation Trust
Margaret Hill – Community Services Manager, Leeway Domestic Violence & Abuse Service, Norfolk
Steve Hems – Head of Environmental Health, a Norfolk District Council
Jackie Schneider – Head of Quality & Patient Safety, a Norfolk Clinical Commissioning Group
Peter Burnham – Head of Community Safety, Norfolk County Council
Gaynor Mears – Independent Chair & Overview Report Writer

1.25 **The Author and Independent Chair of the Domestic Homicide Review:**

1.26 The author of this DHR Overview Report is independent advisor and consultant Gaynor Mears. The author holds a Masters Degree in Professional Child Care Practice (Child Protection) and an Advanced Award in Social Work in addition to a Diploma in Social Work qualification. The author has extensive experience of working in the domestic violence field both in practice and strategically, including roles at county and regional levels. Gaynor Mears has undertaken Domestic Homicide Reviews, and research and evaluations into domestic violence services and best practice. She has experience of working in crime reduction, with Community Safety Partnerships, and across a wide variety of agencies and partnerships. Gaynor Mears is independent of, and has no connection with, any agencies in Norfolk.

1.27 **Parallel Reviews:**

1.28 At the time of writing the Review the Coroner's Inquest has been opened and adjourned.

# 2 The Facts

2.1 Mrs A and Mr B who lived in a Norfolk town had been together for 20 years. The couple had what could be described as an 'open relationship'. There is also evidence to suggest that Mr B was physically abusive to Mrs A during their relationship. The day before her death it is understood that Mr B told Mrs A to leave their home which she did. Later that day Mrs A went to stay with a friend with whom she was having a relationship. Her husband knew of this relationship. The following day Mr B telephoned Mrs A requesting that she come back to the family home to discuss matters. Mrs A was dropped off at the address by her friend; she had insisted that she would be alright and turned down the friend's offer to come with her. Mr B had requested that they both come. Mrs A had intended collecting her belongings and leaving after meeting with her husband.

2.2 Mrs A made a 999 call to the Police at 2.48pm saying that her husband had a shotgun pointed at her. Armed Police and Paramedics were despatched to the address. Paramedics arrived first and found Mrs A on the driveway of the next door house. She had a single shotgun wound to the chest. Efforts were made to save her life, but to no avail and she was declared deceased at the scene.

2.3 Police cordoned off the scene and on entering the rear garden of the family home found the dead body of Mr B at 3.26pm. A shotgun was found under his body. He had sustained a single shotgun wound to the head. An empty cartridge was found near the path at the side of the house suggesting that Mr B had reloaded the shotgun. The shotgun found under his body had one unspent cartridge remaining in the second barrel of the gun. 3 unspent cartridges were found in one of Mr B's pockets.

2.4 In the kitchen of the family home Police found notes left by Mr B giving instructions about the disposal of his estate and funeral arrangements along with the couple's Wills. This suggests that he intended to take his life. There are indications that he planned the events which took place.

2.5 The shotgun used in the shootings was held legally by Mrs A in connection with her interest in clay pigeon shooting. Guns were kept in a lock cabinet, but Mr B knew where the keys were and had access to them.

2.6 A post mortem examination took place and provisional findings made. Mrs A had sustained a single shotgun wound to the left side of her chest which caused major damage to her heart. The post mortem examination found evidence to suggest that the wound was consistent with a close range discharge of a shotgun. There was no other evidence of trauma or injury to Mrs A. Toxicology showed no trace of alcohol or drugs of misuse in her body.

2.7 Mr B's post mortem provisionally found that he died from a single shotgun wound which entered left of the midline to the upper neck. This is a classic site for a self-inflicted gunshot wound. Toxicology found no evidence of alcohol or drugs of misuse.

2.8 From witness testimony given to the Police, the author's interviews and Mrs A's own diaries, it would appear that she had suffered abuse at the hands of Mr B for some years both as a cohabiting couple and during their marriage. Mrs A had a previous marriage which ended after approximately 3 years. Mr B had also had a previous marriage. Information provided to the author confirmed that no abuse took place in his first marriage, nor was there any kind of coercive or controlling behaviour. His first marriage ended due to relationship breakdown.

2.9 There were no other family members present at the time of the incident and the couple had no children.

2.10 Mrs A and Mr B were not considered to be 'Vulnerable Adults' as defined by the Department of Health *No Secrets* policy (Department of Health & Home Office 2000).

2.11 The main agency consistently involved with Mrs A and Mr B was their GP practice. There was a brief one-off use of Mental Health services in 2006, and Police involvement in connection with the granting of a shotgun certificate to Mrs A and one call-out following a 999 call made by Mrs A in August 2011. This callout did not result in Police action against Mr B as Mrs A refused to confirm a domestic abuse assault had taken place and there was no visible evidence of assault or injury on which they could take action. Agency involvement will be covered in detail in the chronology which follows.

# 3 Chronology

## 3.1 Background

3.2 Mrs A and Mr B began their relationship in 1994. They lived together for 10 years prior to their marriage in 2004. Both had been married once before. Following the breakdown of his first marriage Mr B consulted his GP in 1992 for symptoms of depression. It was noted that he attempted to fill his days with work and had difficulty in expressing his emotions. The episode is not thought to have been long lasting. Mrs A had a long history of suffering from depression for which she first consulted her GP in June 1997 when a single prescription for anti-depressant medication was prescribed. There is no information relating to any discussion with the GP, but it was reported that the only identifiable factor was from pressure at work. There was no documentation in medical notes identifying a resolution, nor any further indication of medication to manage the depression. The GP reports that this episode was short lived and self-limiting. While there is no record or evidence to suggest a connection as to the cause of this episode of depression, it is noted that Mrs A had undergone a termination of pregnancy in August 1996. There is no information available about the circumstances, where it was performed or whether it was undertaken privately, and it does not appear that the referral was made by the practice. Information given to the author suggested that Mr B did not want the pregnancy to go ahead hence the termination; he already had children from a previous marriage and did not want another child. However, clinical records show that Mr B had a vasectomy the following year (1997) and the referral reported that he had met a 'new girl' who was very clear that she did not wish to have children.

3.3 It is of significance that Mr B routinely accompanied Mrs A to her GP appointments. This would have impinged on any opportunity she may have wished to take to discuss her health or relationship candidly with her GP had she wanted. According to the GP practice it is not unusual for their practice to see a patient accompanied by their partner or relative.

3.4 Mrs A's earliest diary note which is dated from March 2000 provides an insight into what was taking place behind closed doors. In common with many relationships there were ups and downs, but the downs appear to have involved a range of abusive behaviours. Mrs A's diary notes indicate the influence of alcohol on Mr B's behaviour when she recorded him trying to force himself upon her while he was drunk which she repulsed. Later that month she recorded that he "doesn't seem bothered he is hurting me, said I either like it or lump it, he ain't going to change. What am I doing here?" In 2002 Mrs A recorded that he was drunk again and was "sending me round the bend… Whatever I say he turns around, we're going down hill. Don't know what to do – lived together a long time. Will be like a divorce". A separate note that year states that Mr B was "still sending me round the bend with mental games". Then in July 2002 Mrs A wrote "Mr B and I are fine and so much in love" indicating a happier period in their relationship.

3.5 On 3 March 2003 Mrs A records that Mr B "keeps having paddy about nothing. He's driving me insane. I don't deserve it. If it wasn't for the finance and the cats I would have gone by now".

3.6 On 1 January 2004 Mrs A's diary notes that she had hurt her ankle and she commented "Doesn't take long for Mr B to turn into a sh**. I don't know why. See how New Year starts. We are meant to get married this year!!! Mr B is a waste of space –what a start to the New Year. Never been so bad". A diary entry on 24 April 2004 indicates Mr B talked to her in explicit terms about the sex lives of other couples and wanted them to be the same. Mrs A recorded that she said she "wasn't interested".

3.7 On the day of her marriage Mrs A told a family member that she wondered if she was doing the right thing as she was seeing someone else that she cared for a great deal, but he was not free for them to be together at that time. The marriage to Mr B went ahead. Some have commented that Mr B liked having Mrs A on his arm in public because she was young (14 years his junior) and attractive; informally it has been commented that she was seen as Mr B's 'Trophy Wife'. Their relationship has been described as an 'open relationship'. Both had affairs, although Mrs A's diary gives a strong impression that she was upset when Mr B had an affair which he sometimes carried out in front of her in their home.

3.8 Chronology 2005-2012

3.9 In January 2005 Mrs A saw her GP suffering from depression and insomnia for which she was prescribed anti-depressants. She had previously been diagnosed with a degenerative spinal condition which was causing her severe pain. Mrs A was awaiting surgery for her back pain and she attributed the depression and insomnia to the pain from this condition. GP documentation indicates that she declined counselling, which suggests she was offered it as it may have been of benefit to her, however there is no record of the discussion surrounding this. Mrs A had surgery on her back in March 2005.

3.10 Sometime after Mrs A's marriage two relatives recall her disclosing to them that she had been hit around the head so hard by Mr B that it had affected her hearing for a while; she thought her eardrum had been damaged. Mrs A had also said that she was frightened of Mr B when he had a drink. One of the relatives recalls having an argument with Mrs A after this as they were trying to persuade Mrs A to leave the relationship. The relative believes that Mr B heard this conversation and from this point on this relative reports that they were kept at a distance and ignored by Mr B and their contact with Mrs A lessened.

3.11 Mrs A's diary entries for 2005 are patchy, and contain many notes about the extreme difficulty she is having in sleeping. She had surgery on her spine in March and September 2005. In July 2005 she recorded how after a night out she was taken home by friends and her husband drove home separately whilst he was drunk. She wrote "I'm sorry I'm a mess. I can't cope any more". There is no indication of whether this refers to their relationship, or the pain she was in following surgery. On 24 November 2005 Mrs A's diary notes "Mr B changes from being nice caring to being an arse and doesn't show me any respect and laughs at how I feel. I can't do this, I'm going to explode one day". Entries around this time indicate that she may be keeping a sleep diary "I haven't slept for 4 weeks", and "seeing doctor on Monday if I survive that long!!??" After she saw the doctor Mrs A recorded a change of medication in her diary, and there is an indication of her desperation for a full night's sleep as she recorded taking 3 rather than 1 of her anti-depressants, and on occasion she drank alcohol with the hope of sleeping. After seeing her doctor on 16 December 2005 she recorded that she had been told to persevere with the medication, but she was suffering from extreme tiredness, lack of appetite, and sickness.

3.12 On 31 March 2006 Mrs A saw her GP for depression and was prescribed anti-depressants. The GP reports making attempts at various points to probe reasons for her depression, but Mrs A always maintained that it related to her back pain. On the 19 April 2006 Mrs A was prescribed further medication including a sedative for night sedation. The following month on 3 May Diazepam was prescribed. By 7 July 2006 when Mrs A saw her GP she was reported to be coping and her mood was settling, however, two weeks later she returned to the GP with discomfort thought to be linked to intestinal problems which was affecting her mood and her back pain. She was referred to a specialist, but there is no record of Mrs A keeping the appointments which were offered. On 17 August 2006 Mrs A saw her GP with a cough and symptoms of irritable bowel syndrome. Mrs A's GP received a letter from her orthopaedic surgeon on 22 August 2006 following a review. The letter reported that her back was satisfactory, but the consultant felt that her issues with depression was clouding some of her symptoms. It is not clear what is meant by this.

3.13 Throughout September 2006 Mrs A visited her GP complaining of a continuous cough, however, an examination and x-ray was clear. Over the coming weeks she started to complain of nausea, loss of appetite, weight loss and feeling tired all the time, and in October 2006 she also complained of low mood, abdominal pain and intestinal problems. Investigations ruled out any abnormalities, and it is reported that these symptoms were linked to her irritable bowel syndrome.

3.14 On the 15 November 2006 Mrs A saw the GP once more with persistent intestinal problems and depression. She was prescribed an anti-spasmodic medication and her anti-depressants were increased. There is no assessment of her level of depression documented within the GP records.

3.15 On 17 November 2006 Mrs A was admitted to the Norfolk and Norwich Hospital following an overdose of anti-depressants and alcohol. She had left a suicide note and taken the phone of the hook; this appears to have been a serious attempt which took place during the day when her husband was at work, and she told hospital staff that she was disappointed not to have succeeded. Mrs A was discovered by her parents who had called to the house to see her. Mrs A told staff that she was having marital problems, that she was in love with someone else and her husband knew. She gave this as the reason for taking the overdose. She reported a history of approximately 2 years of being depressed and having suicidal thoughts for approximately 3 months and was seeing her GP every 2 weeks for assessment. It is understood that Mrs A had strong feelings for the

person with whom she was having the affair and was seriously thinking of leaving her husband at this time, but she had been persuaded not to leave her marriage.

3.16 Mrs A was seen by two Psychiatric Nurses on the ward before discharge on 18 November 2006. Her husband was present at this interview. A Care Programme Approach (CPA) Preliminary Risk Screening assessment was completed with Mrs A and an urgent referral to the Crisis Resolution and Home Treatment Team was sent on 19 November with a copy to her GP. Mrs A was also advised to see her GP.

3.17 The reports which were sent to Mrs A's GP by both the hospital A & E Department and the Crisis Resolution Team outlining the events contained limited information. They referred to her continuing low mood, loss of appetite and disturbed sleep patterns, but indicated that these were related to her lower back pain. There was no mention of the relationship difficulties and the part this played in Mrs A's overdose attempt, therefore the GP remained unaware of this aspect of her life.

3.18 On 27 November 2006 the Community Mental Health Team (CMHT) team leader sent a letter to the Crisis Resolution and Home Treatment Team to inform them that Mrs A's referral would not be accepted as a full assessment had not been completed by them.

3.19 As a result of the referral refusal Mrs A's GP wrote to the Community Mental Health Team on 30 November 2006 referring her for ongoing support. The letter emphasised that the overdose had been well planned and appeared to be a serious attempt to take her own life. The letter also referred to a history of high alcohol intake, although Mrs A had managed to reduce this somewhat.

3.20 The GP followed up the referral letter with a phone call on 4 December 2006 requesting that the Community Mental Health Team see Mrs A within 24 hours. There is no documentation regarding Mrs A's state of mind or a risk assessment at this point and no documentation of any concerns raised by Mrs A or her GP in the referral letter to the service. This referral was accepted, and on 14 December 2006 Mrs A was assessed at a home visit by a Community Psychiatric Nurse (CPN). Mr B was present at this assessment. Mrs A's main issues recorded during this assessment were chronic pain for which she had undergone surgery in 2005, low self-esteem and low confidence possibly due to her inability to work, and suicidal thoughts. The plan agreed as a result of the assessment was for medication for depression and anxiety, explore self help work books and group work to address esteem issues, and to offer 8 sessions of talking therapy. A letter filed in Mrs A's medical records from the Mental Health link worker dated 9 January 2007 reporting on the assessment states that Mrs A was seen at home with her husband and that there were no financial or relationship problems, but she had some physical health limitations and that she felt her self-esteem had been destroyed. There is no documented information about what had caused this. The report stated that Mrs A continued to think about death, although she had no plans. An increase in alcohol use was mentioned and an increase in her back pain.

3.21 In the Community Mental Health Team Risk Assessment Mr B is described as 'very supportive', but it is not clear if this is the staff member's opinion or that of Mrs A. Within the assessment used at that time there is no evidence of any steer towards questioning a patient about domestic abuse, but if Mr B was present questioning on this subject would not have been appropriate at this interview. Mrs A attended 7 out of the 8 talking therapy sessions. It is assumed that these were at her local surgery with the Mental Health link worker as they are recorded on the practice electronic records. The sessions took place throughout January to May 2007; one session was missed due to illness. Mrs A attended alone. Mrs A's anti-depressants were managed at a therapeutic dose during this time and some improvement is recorded, although she had become a

little 'high' due to her medication, however it was agreed that she would maintain at that does level. Alcohol was discussed, but was not judged to be a serious problem.

3.22 On 8 May 2007 the Police received an application for a shotgun certificate from Mrs A. The application was supported by her GP who was her referee on the application form. Mrs A disclosed her history of depression and that she was on mild antidepressants. Vetting checks were carried out on Police systems with a nil result. A doctor's report from her GP was received on 31 May 2007 confirming Mrs A's history of depression, but reporting that she had made significant improvements, her mood had improved, but she would remain on medication for the next few months. The application was reviewed by a Firearms Licensing Officer on 7 June 2007 and the decision made to grant the shotgun certificate and this was sent to Mrs A the same day.

3.23 On 18 May 2007 Mrs A's clinical notes record her consultation with her Mental Health link worker. Her mood remained stable and she was making plans for the future and beyond. She was continuing with hobbies and a recent holiday had gone well. However, there was some reflecting on the consequences of her suicide attempt and she was afraid that this meant that her depression was returning. At this point the link worker introduced Mrs A to some self help books; her case was to remain open until the end of June and if they did not hear from her, her case would be closed. There is no further documented contact with the Mental Health Team.

3.24 In the coming months Mrs A's health appears to be more stable with documented GP consultations stating that she felt more stable and she had reduced her alcohol usage. She continued on anti-depressants, night sedation and analgesia.

3.25 The Firearms Licensing Officer visited Mrs A to discuss her application and the GP report on 5 June 2007. Mrs A agreed with the GP report and said she found clay shooting relaxing recreation. She had been attending a Shooting School and was seen to be knowledgeable and safety conscious. The officer decided to recommend Mrs A for a shotgun certificate under category B. This category signifies a slight cause for concern and requires that the holder be visited again within 2 years. On 7 June the application was reviewed by another officer and the decision taken to grant the certificate.

3.26 On 10 July 2007 the Police Firearms Department received notification of the purchase of a 12 bore shotgun by Mrs A from a registered firearms dealer.

3.27 Mrs A next saw her GP on 7 November 2007. She was feeling low again, anxious and tearful for the past 2 months. Her anti-depressants were increased and a blood test undertaken to rule out any physical illness, but nothing was detected. It is not clear whether any assessment was made as to the level of her mood or whether she was at increased risk of self-harm at this point. However, over the next few months Mrs A's mood stabilised once more and by mid January 2008 she was much better, although her back pain was said to continue.

3.28 In February 2008 the GP referred Mrs A for physiotherapy for hypermobility syndrome, a condition where the joints move beyond the normal range expected, and damage is a risk because of this. This would have been particularly pertinent to Mrs A's back condition. She was also prescribed Diazepam for short term sedation, it is presumed for this condition. By March 2008 Mrs A was reported as feeling better once more and she had started a job locally. Her physiotherapy appointments started in April and continued through to July 2008, but there is no specific feedback to her GP relating to this.

3.29 On the 2 December 2008 Mrs A returned to the GP reporting further back pain. She was referred once more to the orthopaedic consultant and following an MRI scan she was referred back to her GP. No significant physiological problems were found.

3.30 In Mrs A's diary notes for 11 April 2009 an entry describes that Mr B was "p***ed off knocked me to the ground - bruised back". Mrs A was referred to the Muscular Skeletal Physiotherapy service on 23 June 2009, but she only attended the first appointment then did not return for further sessions.

3.31 On 13 August 2009 the Police Firearms Department received notification of a gun transaction by Mrs A showing she had inherited 3 shotguns. On the same day an enquiry was sent for an officer to make a reassessment of risk category, and this took place in September 2009 (day unknown). This was to comply with the 2 year reassessment period from the time the certificate was first granted on 7 June 2007. In effect this meant that the reassessment took place 3 months late. It can only be assumed that Mrs A's gun cabinet was inspected to check that it could securely accommodate 4 shotguns during this visit as it is not recorded. Mrs A was still on antidepressant medication, but she had improved. There was a recommendation to change the certificate category from B to C; this category signifies no concern or significant change in circumstances. Visit once in five year life of the certificate.

3.32 Information provided to the author has revealed that in fact Mrs A had not inherited the 3 shotguns. Mr B bought them as an investment from someone who no longer used them. It has also been disclosed that Mr B went to a friend with the 3 shotguns in the back of his car to find out if any of them were valuable. The friend is understood to have told Mr B in firm terms that he should not be carrying the guns around in this manner and to take them home straight away. This event is highly suggestive of a disregard for the law and lack of concern for safety.

3.33 On 13 December 2009 Mrs A attended the Minor Injuries Unit of her local hospital with her husband following an accident at home which had resulted in an ankle injury. It is recorded that she 'fell over the dog last night and twisted her ankle'. She was diagnosed with a fractured distal fibula which required 'internal fixation for non-union'. There was no concern as to the cause of the injury, and there is nothing in Mrs A's diary to indicate that this was anything other than an accidental injury. This injury proved reluctant to heal and in May 2010 Mrs A needed corrective surgery.

3.34 In her one of her diary notes for 2009 Mrs A records the booking of a holiday abroad "happy and excited what a lucky woman – yummy life!"

3.35 Commencing on 15 November 2010 and the first 3 months of 2011 Mrs A saw her GP for a gynaecological problem. Treatment for this continued until just before her death. The only relevant entries in her diary notes for 2010 concerned Mrs A's unhappiness with Mr B having an affair. The description of events indicates this was taking place in front of her in their home on occasions. In one diary note Mrs A wrote that Mr B told her "after 16 years not sure what he wants", but then she wrote that he said he loved her and there was nothing to worry about. Her entry goes on that Mr B told her she was stupid and he talked over her as though she was not there. This was around the time that Mrs A was just about to go into hospital for an operation on her unhealed ankle. Midway through 2010 when she was commenting on his continuing affair Mrs A recorded that Mr B said he was fed up with her drinking and she felt he was blaming her for breaking her ankle, the fact that she was not getting paid, and not wanting him to sleep with the other woman and she wrote this "was enough to warrant a drink". In a diary note on 14 June 2010 Mrs A wrote about her anger at the affair having seen a text on her husband's phone. The diary note recorded that she texted a relative about the

situation, but made them promise not to tell anyone. The relative concerned has confirmed receiving this text at around 3.00am. This was one of the few direct contacts with her relative in recent years. A diary note on 30 October 2010 recalls that Mr B was drunk and was going to drive. Mrs A recorded that she called the Police and so he had to walk home. The note goes on that later that evening Mr B wanted her to have sex with him and another man, but she said no. There are two notes on the Police system that Mr B was known to be a drink driver, but he was never caught.

3.36 On 2 November 2010 Mrs A recorded a diary note "Have cancelled work tomorrow. Mr B too happy hitting me. He has gone off in one hell of a mood. Said I deserved being hit. Have rung in sick". Mrs A's employment record confirms that she was 'off sick' on the 3 November 2010.

3.37 Another diary recording for 2010 refers to Mrs A being paid and paying off all her bills. She worked part time hours. It is understood from information given to the author that the couple had separate bank accounts and one for household bills, but Mr B had paid Mrs A's debts on two occasions. Comments made during the course of the Review also suggest that she was often out socially without money, and her diary suggests that she sometimes had to borrow and pay back money to friends.

3.38 Entries in Mrs A's diary notes in February and March 2011 indicate diverse swings in how she viewed her relationship with her husband. One week she recorded that he "seems to have gone mad. Swearing and cursing like I've never heard – I'm frightened". The following week Mrs A recorded that he was "everything to me". An entry a week later indicates that Mr B's affair may still be going on, but Mrs A thought they "had got over it 3 weeks ago". At the end of March Mrs A wrote that her husband "is right moody and won't speak to me. I'm getting everything wrong".

3.39 On 7 April 2011 Mrs A was seen by paramedics after she collapsed following a coughing fit; although they identified that she had had a panic attack. Mrs A's diary note that day records that her husband was "not bothered", but in an entry for later that day she wrote that he was okay and she loved him. The following day on 8 April 2011 Mrs A saw her GP and was reported to have a bad chest and had a coughing fit and collapsed. She was also reported to be coping well with her depression.

3.40 In a diary note of 2 July 2011 Mrs A recorded that Mr B "just had a hissy fit, thru phone at me and then tried to swear at me. I've just stood there and watched". Mr B then accused her of being drunk, but she writes "I'm not I'm on water". "He then emptied the whole bottle of whiskey into a pint glass and told me to drink it".

3.41 On 9 August 2011 the Police received a 999 call at 21:59hrs from a landline address. The female caller was distressed and saying "help me". The call taker commented that it sounded like her husband has attacked, and a male was heard in the background. Officer 1 and Officer 2 where despatch to the address at 22.03hrs and arrived at 22.27hrs. Mr B opened the door and invited the officers in. He knew Officer 2 personally. Mr B denied that there had been any altercation or that there had been a phone call to the Police. Mr B was assessed by the officers as being intoxicated. He maintained that he had only just arrived home and therefore there may have been another man in the house. Officer 1 went outside to confirm the caller and address details and was told that the call was made from the landline by a female and the information given to the officer suggested that the man may have assaulted her. When Officer 1 returned to the house Mr B was talking to Officer 2 and was just closing the door saying that his wife was asleep. Officer 1 told Mr B that they needed to check on the welfare of the female who had made the call from the address. Officer 2 spoke to Mrs A on her own in her bedroom and Officer 1 spoke to Mr B on his own. Mr B denied

anything had occurred and requested that Officer 1 telephoned a named senior officer in the Constabulary saying "he will sort this out". Officer 1 refused to do this. Officer 1 then went to join Officer 2 with Mrs A. She was in bed under a duvet. Officer 2 asked Officer 1 to talk to her as it had not proved possible to establish the facts. Mrs A was noted as being intoxicated; she admitted that she had called the Police, but there had been a verbal altercation only. When asked, she refused to confirm or deny that she had been assaulted. A DASH[3] risk assessment was completed and calculated to be 'standard' risk. Police databases were checked following this callout and no previous domestic incidents were recorded on Police systems. There was no visible evidence of assault and no complaint made to enable further action. Following this incident Mr B made a complaint about the attending officers which was not substantiated.

3.42 Mrs A's diary note for the evening of 9 August 2011 confirms that Mr B had assaulted her, she recorded that the Police had been to the house and "Mr B has assaulted me. Really sh***y", and that he "hit me a lot. He went to town. We have had Police around because Mr B had a good time with me!!!". "He is full of drink so I'm not gonna run him down, we are both under the influence so we are both bad."

3.43 On 23 August 2011 Mrs A saw a Practice Nurse. She had been experiencing migraine type headaches with flashing lights, clouded vision and nausea. She was advised to see an optician and treated with anti-migraine medication plus routine blood pressure test. When she saw the GP on 19 September 2011 the migraine headaches had resolved.

3.44 In a diary note for 30 October 2011 Mrs A recorded that her husband "told me to f*** off from the lounge. He's had too much to drink. He needs to know what he said to me. He started to get violent. When we go away there will be no raising of fists or bad language".

3.45 On 24 November 2011 Mrs A's diary entry recalls that she had found a message on Mr B's phone indicating that he was having an affair. She wrote that she "kicked off" at her husband and smashed his tablet computer. "He's taken me for a fool this last 8 months. Can't believe it".

3.46 On 2 January 2012 the tone of Mrs A's diary entry changes and she records having had a wonderful Christmas and New Year and that she and Mr B had "thanked each other for the wonderful times". But by the end of the day's entry the tone changed yet again. They went for a walk and ended up at a local pub which they frequented regularly. When it came to returning home Mr B was drunk and so Mrs A ordered a taxi. Mr B refused to get in or to give her keys, and Mrs A had no money to pay for the taxi. When she arrived home she had to wait for Mr B to arrive; when he did she records that he was moody and became physical and tried to make her have sex. He was "shouting that I needed a whiskey. It was very frightening". Mrs A also recorded that Mr B said that she was drunk at a function they had attended and he was ashamed to know her.

3.47 On 27 January 2012 and 13 March 2012 Mrs A saw a Clinical Practitioner at her GP surgery. At the March appointment she was noted as 'struggling with symptoms of emotional upset and tearfulness'. She was diagnosed with early menopause and prescribed medication. When she saw the Clinical Practitioner again for follow-up on 30 July 2012 she reported that the medication was helping with her mood swings.

3.48 Mrs A's shotgun certificate was due to expire on 6 June 2012. A certificate renewal letter was sent to her on 9 March 2012 from the Police Firearms Licensing Unit and

[3] Domestic Abuse, Stalking and Harassment (DASH) risk assessment - 27 evidence based questions which assist in assessing the risks faced by victims of domestic abuse.

vetting checks carried out via a search of Police databases (PNC, CIS, CATS). A crime report reference number 38445/11 was reviewed which recorded the Police attendance at Mrs A's address on 9 August 2011 following the 999 call in relation to the alleged domestic abuse incident. A visit to Mrs A was made regarding the renewal on 21 May 2012 by a Firearms Enquiry Officer. The results of the vetting checks were forwarded to the Firearms Enquiry Officer. There is no indication that the incident on 9 August the previous year was discussed with Mrs A during this visit. Mrs A had a total of 4 shotguns; 1 she had purchased for clay pigeon shooting and 3 she had 'inherited' (but were actually purchased by Mr B). She had been a shotgun certificate holder for the 4 shotguns since 10 August 2009. The renewal application was countersigned by one of the couple's friends. Her application showed that she was still on medication for depression, which Mrs A said was due to work related issues and she continued to take a low dose anti-depressant. The renewal was reviewed and discussed with a Firearms Licensing Officer on 23 May 2012 and in the discussion it is noted that Mrs A only used one of the guns for clay shooting and does not keep ammunition in the house, but that she purchases cartridges as required at the clay shooting venue. There were no concerns that she was a risk to herself or others and the renewal was granted. On 24 May 2012 a routine notification letter was sent to Mrs A's GP surgery addressed to the senior partner informing them of the renewal and asking that the Constabulary be notified if there were any reasons why Mrs A's shotgun certificate should not be renewed. No response was received from her surgery.

3.49 The incident of a Police 999 call out to Mrs A's address on 9 August 2011 was not previously known to the Unit. It came to notice when the vetting procedure was completed. However, under the regulations and risk assessment followed by officers it would have been most unlikely to change her risk category to preclude the continuing granting of a certificate.

3.50 In her diary note of 24 June 2012 Mrs A recorded "He's hit me and smacked me, nothing to worry about now. He changes like the devil !!!."

3.51 Mrs A saw her GP on 10 August 2012. An ultrasound identified an ovarian cyst and in view of her discomfort she was referred to a gynaecologist. Mrs A received an appointment on 10 October 2012 and for a day surgery procedure on 8 November 2012.

3.52 On 13 August 2012 Mr B was seen at the Norfolk and Norwich Hospital Ophthalmology Department in relation to treatment for glaucoma in both eyes. Other than attending with his wife, Mr B's involvement with his GP and Health services revolved around his treatment for hypertension and the eye condition.

3.53 Mrs A was seen at her GP surgery on 14 November 2012 and again by her own GP on 21 November 2012 in connection with ongoing treatment for a gynaecological problem. During the appointment on the 21 November she also reported 'an aggravation' of her depressive illness which she attributed to hormonal changes relating to her problem.

3.54 Information given to the Police and the author confirm that Mrs A had been thrown out of the marital home at the beginning of December 2012 by Mr B. It is alleged that Mr B told one of Mrs A's female friends and one of his friends that Mrs A was impeding his career. He had said this to Mrs A when he threw her out of the house. He also told her that she would get nothing; no clothes, no property. She was found crying by a friend in the pub the couple frequented. The friend then telephoned another friend with whom Mrs A had recently started a relationship. He collected Mrs A and she stayed at his house that night. They discussed a number of options about where she could live, including her moving away to a flat in another town. Mr B was aware of Mrs A's

relationship with the man who gave her accommodation that night, and some contributors to the Review commented that Mr B suggested to the man that he take Mrs A out while he went out at weekends. The relationship did not seem to cause a rift between them.

3.55 On the following day Mr B phoned Mrs A and said he wanted to see her. Mrs A told her friend 'I think I'm going to leave him'. She intended to collect her clothes and her car and return. Her friend offered to go with her as Mrs A had told him that Mr B used to "knock her about quite badly", although he had not done so for a while. However, Mrs A said that Mr B had assured her he would not hurt her and she thought that her friend's presence could inflame the situation. Information provided from another friend confirmed that Mr B had texted them and wanted them to make sure that Mrs A's friend did in fact go to the house with her. Mrs A's friend drove her to near the house and last saw her standing on the driveway talking to Mr B.

3.56 At 2.48pm that day Mrs A called 999 to say her husband was pointing a shotgun at her threatening to shoot her. Police and paramedics attended and found Mrs A shot dead. Mr B was found shot dead in the back garden of their home with a shotgun beside him. His wounds were consistent with a self inflicted gunshot wound. Notes found left out in the house included one setting out his wishes for funeral arrangements, and the couple's Wills were out on a table. Before he shot himself Mr B had also phoned a friend to come to the house and collect the couple's dog and asked that they call the Police.

# 4 Overview

## 4.1 Information about the victim:

4.2 Mrs A was an attractive, bubbly, and gregarious woman. She loved to dress up for social occasions and would accompany her husband to local events connected to some of his duties locally. One contributor to the Review reported that in the last few years Mrs A seemed 'not a very settled person', who sometimes exhibited 'attention seeking behaviour'; and it appears that her husband had been paying less and less attention to her in recent months as his local commitments grew. She has also been described as a larger than life character who would not say a bad word about anyone.

4.3 It is clear from the many references within clinical records and from some of her own diary notes that Mrs A suffered from low self esteem and low confidence. This may have been the result of being in a marriage in which she seems to have been controlled or abused and belittled verbally. Her diary notes mention 'mental games' and put downs, and a contributor to the Review recalled hearing Mr B put her down verbally in public. Such put downs and psychological abuse can have lasting negative affects; feelings of low self-worth, loss of self respect, depression, loss of confidence and hopelessness are all psychological and emotional effects of short, medium and long term domestic abuse[4]. The reasons for her low self esteem were never explored or never documented by the professionals with whom she had contact. A relative has described how Mrs A was usually full of life, but around her husband she always seemed on edge, and she had admitted that she was frightened of him, especially when he had been drinking.

4.4 Despite being on anti-depressants Mrs A drank alcohol, and sometimes she drank to excess. Mr B did not attempt to stop this; a contributor to the review thought Mrs A

[4] Shipway L (2004) *Domestic Violence A handbook for health professionals*. London, Routledge.

would have made a scene had he tried to do this in public. Her behaviour in public was said by some as beginning to cause Mr B embarrassment as his aspirations grew in connection with his local interests and commitments. However, there is evidence from Mrs A's diary notes in 2006-2007 that she was monitoring her alcohol intake, and at that time she appeared to be using it as a means to induce sleep as she was suffering from very bad insomnia. There is also mention in her diary of Mr B trying to make her drink when he was drunk and she was not (see paragraph 3.39).

4.5 There is no evidence to suggest that Mrs A was dependent on alcohol, but observations of her excessive alcohol use in public situations on occasions might have been a manifestation of its use as a coping mechanism, a disinhibitor to mask her low self esteem, and a misguided means of dealing with her depression and unhappiness. The couple's social life also revolved around social situations where drinking alcohol was the norm, but whereas Mrs A's intoxication attracted criticism from her husband and comment from others, his own excessive drinking and intoxication attracted little or no comment.

4.6 Mrs A did disclose to some members of her family on one occasion a few years after her marriage that she had been hit by Mr B, and one family member tried to persuade her to leave. However, the family member concerned thought that Mr B overheard the conversation, and following this contact with Mrs A and her husband all but ceased. Mrs A had also told some friends about being physically assaulted by Mr B one of whom reported that they were told by Mrs A that Mr B hit her so regularly she was used to it, and Mrs A had said "he's done it so often it doesn't matter". The friend told Mrs A that it was not right, she should not put up with it and she should get out. Mrs A had said she could not do that; she did not want to let people down.

4.7 It would appear that Mrs A had seriously considered leaving the relationship on at least two occasions prior to the separation just before she was killed. It is an indication of her acute unhappiness about ending a relationship with another man that she tried to commit suicide in November 2006. Low self esteem, depression, suicide attempts and alcohol misuse are well known effects of living with domestic abuse; abused women are 15 times more likely to abuse alcohol, 5 times more likely to attempt suicide and 3 times more likely to be diagnosed with depression than non-abused women[5]. Her difficulty in leaving the relationship is not unusual. Women may attempt to leave an abusive relationship several times before successfully leaving safely. Leaving is a process and not necessarily a one off event. Mrs A's need for financial security, consciousness of public perceptions, and possibly pressure from Mr B resulted in her staying and not able to break free from the abusive marriage. This is not uncommon for women in her position who have not only been physically abused, but who have been psychologically undermined for years. Her comments to a friend that Mr B had hit her "so often it didn't matter" indicates that she could have normalised this way of life as a psychological response to living long term in an abusive relationship, but one which had regular intervals of reward in the form of gifts and luxury holidays. Many working in the field of domestic abuse will recognise this pattern; abusive behaviour followed by gifts to keep the victim in the relationship. To contemplate leaving what appears to be a comfortable and enviable lifestyle to possibly live alone in diminished circumstances can be difficult to face. This fear and the fact that she did express her love for Mr B when he was not being abusive, was possibly the magnet that kept her in the relationship for so many years.

4.8 **Information about the perpetrator:**

[5] Stark E, Flitcraft A (1996) *Women At Risk: Domestic Violence and Women's Health*. London, Sage

4.9 Mr B's public persona appears to have been contrary to his private life. He was heavily engaged in local activities and various local organisations and was seen as someone who was community minded, and very dedicated to his public role and to local people. Much of his time was spent attending meetings and events, and he was seen as an excellent leader. Mr B was also considered to be kind and generous, and he had a good sense of humour. He was very gregarious and he and Mrs A had a very full social life which revolved around local events, his membership of local organisations, their circle of friends, and their local pub. They were viewed as a fun-loving very outward-going, well known couple, and Mr B was said to be proud to have Mrs A on his arm. The couple took regular holidays abroad and in the UK mainly with friends. Their 'open relationship' appeared to be well known, and Mr B's 'colourful private life' has been acknowledged by contributors to this Review.

4.10 He and Mrs A were regulars at a local pub and he would sometimes drink to excess. There are strong suggestions that he was known to drive home when over the drink drive limit. One contributor to the Review recalled taking his car keys from him when he had been drinking and Mr B indicated that it was okay due to his position in the local community. Outside the home he was not thought of as aggressive or argumentative when he had 'had a few beers,' or someone who would swear, but in Mrs A's diary notes there are many descriptions of abuse when he was drunk, including being verbally abusive and swearing.

4.11 Mr B has been described as not the kind of person to show emotions or talk about feelings, and a family member and a colleague report having no hint that things were not right with his marriage, but say that he would have been unlikely to discuss this even so. Mr B is reported by some contributors to the Review to have doted on his wife, but he appeared to be embarrassed by her behaviour on occasions and a gap developed between them as he gave more of his time and commitment to his local duties and interests and she felt ignored. There were rumours that Mrs A was going to leave him.

4.12 **Summary of information known to the agencies and professionals involved about the victim, the perpetrator and their families.**

4.13 Mrs A had numerous contacts with her GP practice for a variety of symptoms; in 2006 the year Mrs A attempted suicide she saw her GP 13 times before she was admitted to hospital due to the overdose. In 2007 in addition to the 7 sessions with a Mental Health link worker she saw her GP 10 times. Throughout the clinical notes there is no information concerning any relationship difficulties or domestic abuse. Both she and Mr B used the same GP practice and had done for many years; Mr B since 1977, and Mrs A since 1995. Generally Mrs A saw the same GP, on a few occasions she did see other GP's in the practice, and she also saw other community professionals such as a practice nurse and physiotherapist. The couple had social connections with some members of the medical practice team. The Independent Management Review found documentation throughout the GP records to be brief to none existent which provided a challenge when gathering information for this Review.

4.14 Mr B had contact with his then GP in 1992 for symptoms of depression following the breakdown of his first marriage; it was noted that he had difficulty in expressing his emotions and attempted to fill his time with work. In more recent times Mr B saw his GP for routine monitoring of minor health ailments.

4.15 On 17 November 2006 when Mrs A attended hospital due to an attempted suicide information was recorded that she was having relationship problems and that she was having an affair which her husband knew about. She gave this as the reason for her overdose. She was admitted overnight and assessed by the Mental Health Crisis

Resolution Team. The report sent to the GP from both A & E and the Crisis Resolution Team contain limited information and no information about Mrs A having relationship problems. They relate her low mood to her back pain. There is no indication that domestic abuse was raised at this time in either A & E or in the assessment by the Crisis Resolution Team.

4.16 Between January and mid May 2007 Mrs A received 7 sessions with a Community Mental Health link worker. The initial assessment carried out with Mr B present reported that there were no financial or relationship problems. The cause of her depression was explained as being linked to physical health limitations, and Mrs A felt her self esteem had been 'destroyed', but there is no documentation about the cause of her loss of self esteem and no indication that relationship problems were discussed in future sessions, or that domestic abuse was raised.

4.17 The Police attendance at the couple's home following a 999 call on 9 August 2011 was the first time information about domestic abuse was received by an agency. The fact that there had been no previous callouts, and no crime was identified or complaint made on this first occasion meant that no further action would be taken or information shared. Officers attending this incident were unaware that a shotgun certificate holder was present at the address as no checks were made at that time.

4.18 The Officers in the Firearms Licensing Unit of the Police had information regarding Mrs A's depression and had GP confirmation that this was not sufficiently severe to prevent the granting of the shotgun certificate she had applied for in June 2007. At that time Mrs A was granted the certificate under Category B. The risk assessment system operated by the Firearms Licensing Unit uses categories A, B and C when assessing the granting of certificates. Category B is used where there is some minimal concern or some change in circumstances and will indicate that the certificate holder should be visited at least once in every two-year period. When the two year visit took place in September 2009 the category under which Mrs A's certificate was granted was changed to Category C indicating no concern and no significant changes. Section 28(1b) of the Firearms Act 1968 (as amended) states that "*an applicant shall, in particular, be regarded as having a good reason if the gun is intended to be used for sporting or competition purposes or for shooting vermin; and an application shall not be refused by virtue of that paragraph merely because the applicant intends neither to use the gun himself nor to lend it for anyone else to use".* In other words there was no reason in law for Mrs A to be refused a shotgun certificate.

4.19 The fact that Mrs A's GP was her referee for the shotgun certificate application meant that they were aware of her making, and ultimately being granted, the certificate.

4.20 On the 9 March 2012 a notification of renewal letter was sent to Mrs A for her shotgun certificate and the vetting process was undertaken. This revealed the 999 Police call out to what was suspected to be a domestic abuse incident on 9 August 2011. This information was forwarded to the Firearms Enquiry Officer. When the visit to Mrs A took place for the renewal of her certificate on 21 May 2012 there is no record to suggest that this incident was discussed with Mrs A.

4.21 Any other relevant facts or information.

4.22 It is unlikely that the domestic abuse incident would have prevented the granting of the shotgun certificate at that time. Guidance issued by the Association of Chief Police Officers (ACPO) on 23 February 2013 has stressed the need for Safeguarding Departments and Firearms Licensing Units to work together to ensure that robust action is taken wherever there are signs of domestic abuse incidents involving a certificate

holder. The guidance includes the recommendation that where a Chief Officer is considering the suitability of the certificate holder in these situations all firearms and ammunition should be removed to prevent any retribution by the certificate holder on his/her partner. In 2012 when the Firearms Unit undertook its vetting process this was the first notice they had of the Police callout to a suspected domestic abuse incident. In August 2013 amended guidance was issued by the Home Office which also elaborates on the steps to be taken when assessing certificate applications where domestic abuse is known or suspected (Please see section 8 page 34 for additional information received after the completion of this Review).

4.23 **Examples of best practice.**

4.24 The Police Officers attending the 999 call on 9 August 2011 followed best practice in ensuring that they interviewed both parties separately, and they undertook their enquiries as best they could considering both parties were intoxicated. As would be expected of an Officer of the law they did not succumb to pressure or implied intimidation from Mr B when he tried to use his connections within the Constabulary to make them leave without carrying out their enquiries.

4.25 Mrs A's GP acted in the best interests of his patient when he challenged the Community Mental Health Team's decision not to accept a referral for her in November 2006. The GP's actions achieved the involvement of the Mental Health link worker and the sessions which followed.

# 5 Analysis

5.1 For clarity the analysis of the events under consideration in this Review will follow the questions raised in the terms of reference. The first item in the terms of reference to review the events and associated actions that occurred from 2005 up to the date of the death of Mrs A has been achieved in the chronology and information known to agencies. These events will be referred to when relevant within the following analysis.

5.2 Before progressing to the terms of reference a comment on the use of the victim's diary notes is necessary. Mrs A's diary notes have provided an insight into her life and quotes have been used in this Review where they provide evidence of her experiences. Efforts have been made to validate those experiences where possible from other sources. It is reasonable to assume that Mrs A did not write the explicit notes that she did with the intention that they would be found and read by others. It is therefore equally reasonable to give them credence for being her honest feelings and recording of events at the time. For example her diary note following the Police call out to the domestic abuse incident is dated that day, and although the hand writing presents as unsteady, there is a strong likelihood that it was written the same evening. As a consequence the author feels justified in giving the victim's own words as a valid contribution to the Review.

5.3 Review the quality and scope of action/s and services provided by the agencies defined in Section 9 of the Act which had involvement with Mrs A, her husband Mr B and other individuals e.g. friends, extended family, or employers, as identified within the agencies' records, Individual Management Reviews (IMR) or other information sources as deemed appropriate.

5.4 The agency with the greatest involvement with Mrs A and Mr B was their GP practice. Whilst access to their GP was clearly excellent judging from the number of consultations, the quality of the documentation in relation to those consultations was found to be brief or none existent by the Independent Management Review author for the service. This

not only provided a challenge for this Review, but would clearly prove an obstacle for practice staff trying to provide continuity of care.

5.5 Mrs A first saw her GP for symptoms of depression in 2005. Her longstanding depression and other illnesses appear to have been treated with long term medication rather than referring on for further treatment and successfully identifying the cause. The fact that Mrs A said her depression was related to back pain on some occasions, and then to work related issues at other times raises the suspicion that she was concealing the real reason. Only once, after her suicide attempt in 2006, did she have access to Mental Health services. From 2009 NICE Guidance (CG91 Treatment of Depression in Adults with Chronic Health Problems and Depression in Adults updated 2009) was in place which recommended a process for her depression to be managed. This guidance supports a clear assessment which includes assessment of the risks relating to self harm. This assessment should be documented. However, there is no documented evidence to suggest that this was followed. The GP has stated that they regularly discussed the management of her depression, but Mrs A was reluctant to consider alternatives. Other impacts identified as affecting the health of women experiencing domestic abuse are irritable bowel syndrome[6], gastrointestinal disorders and gynaecological problems, greater use of alcohol, depression, anxiety, insomnia, and suicidal ideation[7]; all problems experienced by Mrs A to which a knowledgeable practitioner might have given consideration.

5.6 There is no evidence to suggest that the GP's who saw Mrs A considered that domestic abuse might be an issue or considered asking appropriate questions to see if Mrs A was experiencing domestic abuse. Yet of the agencies approached for support by women who have suffered domestic abuse GPs are the second most likely after the Police[8]. However, had they contemplated this it would have been difficult to achieve as Mr B accompanied her to GP appointments. He was seen as supportive; no consideration was given that his attendance at her appointments could have been to prevent her discussing problems with her GP openly. Staff at the practice also knew the couple socially and this may have inhibited asking questions about their relationship.

5.7 It has to be acknowledged that Mrs A's contact with the Mental Health services was in 2006 and ended in May 2007. There have been many changes in the service in the intervening period of time. However, in relation to domestic abuse 2007 is not the dark ages, and it is relevant to point out that Multi-Agency Risk Assessment Conferences (MARACs) have been in operation in Norfolk since 2007 and the county has a long history of promoting multi-agency working. In terms of her mental health the service Mrs A received from the Mental Health link worker appears to have been effective in improving her state of mind for a period of time, but as with the GP service, there is no evidence to suggest that questions about domestic abuse were considered or asked, and once again Mr B was present at the initial assessment interview on which the management of her care was based. There would have been no likelihood of Mrs A disclosing domestic abuse or discussing the reason for her suicide attempt with her husband in the room. Mrs A did have 7 sessions with the link worker on her own, but it is likely that the initial assessment set the parameters of what would be discussed; no mention of relationship difficulties arose in those sessions, or if they did it was not documented. Similarly, the Mental Health assessment in the hospital following her suicide attempt was done with her husband present. Yet, Mrs A had disclosed in A & E

[6] Shipway L (2004) *Domestic Violence A handbook for health professionals*. Routledge, London.

[7] Golding JM (1999) *Intimate partner violence as a risk factor for mental disorders: a* meta-*analysis*, Journal of Family Violence, 14(2), 99–132.

[8] McGibbon AC, Fulham Council Community Police Committee. *Domestic Violence Project*. The Polytechnic of North London, 1989 cited in *Domestic Violence a Health Care Issue?* British Medical Association 1998

that she had relationship problems and loved someone else and this was the reason for her suicide attempt. This was passed from A & E to the Crisis Resolution Team. Given that abused women are five times more likely to attempt suicide, and a third of all female suicide attempts are linked to current or past domestic violence[9], the service delivered by A & E and Mental Health should have been alert to this in their assessments and seen Mrs A without her husband present at the assessment stage.

5.8 The Police Officer's response to the 999 call in August 2011 was well handled, especially in light of the attempt to influence Officer's handling of the situation by Mr B when he named a senior Officer in the force who should be called. Officers made sure they interviewed the couple separately and made appropriate checks for any previous incident reports. It cannot have been an easy incident to deal with as both Mr B and Mrs A were intoxicated at the time and Mrs A was denying that any assault had taken place, although she did confirm that she had phoned the Police, but due to a verbal altercation. Mr B denied a call had been made. Even though the couple were interviewed separately it is not surprising that in the absence of any visible evidence of injury Mrs A would not confirm an assault with her husband in the next room. It would be helpful for Officers to remember that victims of domestic abuse rarely call the Police for a first assault; it is estimated that a woman may experience up to 35 assaults before calling the Police[10]; and evidence suggests that Mrs A had been experiencing assaults for many years. It is of note that Mrs A called the Police on this occasion; was the assault more frightening this time or becoming more severe to make her call 999? It would help Officers when interviewing the perpetrator and the victim to be mindful of the fact that there will undoubtedly have been occasions of abuse before their intervention.

5.9 A DASH risk assessment was completed for this incident and calculated as 'standard' risk. It would appear that the Officers would not have known at this time that there was a shotgun certificate holder at the address. The Police are not able to conduct checks on all relevant databases regarding firearms access or possession prior to attending a domestic incident as it is not considered to be practical due to the number of checks required per person or address on each occasion. Where there is a concern regarding firearms access, or intelligence to suggest this is the case, a check would be completed. All domestic crimes and incidents are referred to the Safeguarding Hub and it is here that all crimes receive a second risk assessment and are reviewed, and all high and medium risk domestic incidents are secondarily risk assessed and reviewed. A 10% dip sample of standard risk domestic incidents also have a second risk assessment and review. High risk victims are referred to CAADA[11] accredited trained Independent Domestic Violence Advocates, whilst victims at medium risk and below are referred to Victim Support project workers who have received specialist training by CAADA; this service will also accept non-crime cases if Officers refer them. The PNC[12] database provides information that an individually named person is a firearms license holder but does not enable a search on an address. It is arguable that the number of databases and various ways in which information is stored must surely hamper the timely retrieval of information for frontline officers and for those doing risk assessments. If the Officers attending the 999 call had known there were shotguns on the premises would they have acted differently? Would they have removed the shotguns as ACPO now recommends?

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[9] Stark & Flitcraft (1996) *Women at risk: Domestic Violence and Women's Health* and Mullender A (1996) *Rethinking domestic violence: The Social Work and Probation response* Cited in Barron J (2005) *Principles of Good Practice for working with women experiencing domestic violence Guidance for mental health Professionals* Bristol, Women's Aid

[10] Jaffe P, Burris C. (1982) *An Integrated Response to Wife Assault: A Community Model.* Cited in Dutton D. (2006) *Rethinking Domestic Violence*. Vancouver BC, USC Press

[11] The Coordinated Action Against Domestic Abuse (CAADA) is a voluntary organisation which provides accredited training for Domestic Violence Advocates (IDVAs)

[12] Police National Computer (PNC)

5.10 The Police domestic abuse booklet which is completed by officers attending an incident also contains a tear-off section giving telephone helplines and domestic abuse support agencies, and it is the custom to leave this with the victim. Whether this would have been taken notice of by Mrs A at the time is debateable as she had been drinking. No further action was taken following the incident as there was no complaint and no evidence to pursue, so the service stopped there. However, this kind of situation is one which would benefit from a follow up phone call to the victim at a safe time to give them a chance to discuss the callout in the cold light of day, and without their partner being present.

5.11 The Firearms Licensing Unit acted appropriately and according to legislation. There was nothing about Mrs A that prevented them from granting her a certificate to hold a shotgun. Even if the Firearms Enquiry Officer had discussed the attendance of the Police to the 999 callout with Mrs A at the visit for the renewal process this would not have been sufficient to forbid the granting of the certificate. However, it would have given the Officer chance to discuss gun safety and impress on Mrs A the need to keep her gun cabinet keys secure, even from her husband as he was not a certificate holder. The ACPO guidance issued in February 2013 rightly directs Police Safeguarding and Firearms Licensing Units to work closely together to ensure that appropriate action can be taken when a shotgun certificate holder lives in a household where domestic abuse is identified. However, this relies on the assumption that all domestic abuse cases are notified to the Safeguarding Unit which may not be the case for all domestic abuse incidents. It also assumes that it is the perpetrator of the abuse who is the certificate holder who could then use their weapon in retribution against their victim. In this case the victim was the certificate holder, but the perpetrator accessed the gun cabinet and ammunition. It would be safer to remove weapons from a household where domestic abuse is identified regardless of who the certificate holder is.

5.12 The contributors to this Review to whom Mrs A disclosed the assaults she had experienced over a number of years were not aware of any routes to support services that they could direct her to. They had not seen any information, posters or leaflets giving helpline numbers locally that they could give her. It is easy to assume that by now everyone knows about domestic abuse and where to go for help. This is not the case. More needs to be done to make information as widely accessible as possible in a variety of multi-agency settings as well as in public venues. GP surgeries need to display posters and have leaflets easily available; having them available in the toilets would enable patients who are accompanied by a partner or family member to pick them up unseen.

5.13 Examine the knowledge and training of staff involved in relation to the identification of indicators of domestic abuse and the use of appropriate risk assessment i.e. the DASH risk assessment checklist, agencies own specialist risk assessments, and knowledge and use of appropriate specialist domestic abuse services.

5.14 Staff in the GP practice readily admit that their knowledge and management of support for domestic violence and abuse victims lacks skill and expertise. There is currently no mandatory requirement for independent practitioners such as GPs or practice staff to undertake training around domestic violence. There is currently no knowledge of the DASH risk assessment or other appropriate knowledge needed to adequately identify domestic abuse victims and to direct them to specialist agencies for support. GPs and their practice staff would benefit from training in Identification and Referral to Improve Safety (IRIS), an evaluated training scheme for practice staff including GPs, nurses, and administrative staff developed by Professor Feder of Bristol University and colleagues which also includes developing practice links with a dedicated specialist domestic violence advocate. The IRIS system was developed to assist GP surgeries to improve

their identification and support for their patients experiencing domestic abuse. In a randomised controlled trial IRIS participating practices identified three times as many women experiencing domestic abuse than the control practices[13], and their referral system to Independent Domestic Abuse Advocacy services for those women who wanted it meant that victims were support appropriately. It is acknowledge that GP consultation times are limited and practitioners often work under considerable pressure, however, the investment in time necessary to train and operate the IRIS system is compensated for by a reduction in patient visits and the IRIS research suggests cost savings.[14]

5.15 The lack of questioning and risk assessment by Mental Health professionals about Mrs A's relationship difficulties following her suicide attempt may be mitigated against now due to a radical change in assessment, review documentation, and training for Mental Health professionals. The Norfolk & Suffolk NHS Foundation Trust current Care Programme Approach (CPA) assessment published in 2012 (CPA Assessment: (C98:CPA) Version 1.0. Published October 2012. Review April 2013) does promote the clinician to ask direct questions about vulnerabilities, dependents, domestic abuse and safeguarding, and training in the use of the CPA assessment is mandatory, as is safeguarding training. However, there is currently no confidence that specific training in identifying and risk assessing domestic abuse exists for Mental Health professionals which would adequately prepare them to identify and approach service users sensitively to enable them to complete this section effectively.

5.16 Frontline Police Officers receive training relating to Domestic Abuse, Stalking & Harassment & Honour Based Violence Risk Assessment Training (DASH 2009). This is delivered to all front line response officers and support staff. The aim of this training is to provide a response to vulnerable victims experiencing domestic abuse. Training sessions which take approximately 3 hours are delivered to all new officers in the force as part of their initial training. The training was initially delivered by an officer who had attended the Train the Trainer session given by NPIA[15] supported by ACPO and Criminal Behavioural Psychologist and ACPO Consultant, Laura Richards. The training covers power & control methods used on victims by perpetrators; Officers responsibilities in relation to: risk identification, assessment & management; and some of the lessons learned from the risk identification, assessment and management process. There are still a small number of officers and front line support staff in the force who still require the initial DASH training session. Whilst appreciating the pressures faced in taking Officers from duty for training, 3 hours does seem a modest amount of time to cover all aspects of domestic abuse. The force should endeavour to complete the necessary training for the remaining officers as soon as possible.

5.17 Examine the effectiveness of single and inter-agency communication and information sharing, both verbal and written.

5.18 The failure of the hospital A & E and Mental Health Crisis Resolution Team reports to include any mention of Mrs A's relationship difficulties to the GP following her suicide attempt in 2006 meant that her GP was ignorant of this part of his patient's life. This knowledge may have led to a different approach in their consultations. It is the practice to write to the GP updating them of any assessment (either when referred from the GP or

[13] Feder G, et al (2011) *Identification and Referral to Improve Safety (IRIS) of women experiencing domestic violence with a primary care training and support programme: a cluster randomised controlled trial* at www.thelancet.com/jounals/lancet/article/PIIS0140-6736(11)61179-3/

[14] Devine A, Spencer A, Eldridge S, et al (2013) *Cost-effectiveness of Identification and Referral to Improve Safety (IRIS), a domestic violence training and support programme for primary care: a modelling study based on a randomised controlled trial*. Bmjopen.bmj.com accessed 1 May 2013.

[15] National Police Improvement Agency

emergency via an acute general hospital's A& E Department). The expectation is that the letter will contain key clinical detail of the patient's presentation, analysis of the presentation, interventions applied and any recommendations for the GP. It is to be hoped that this expectation is met in practice, however in terms of assurances of best practice and the quality of this information there is no audit completed into this area. A regular dip sample to check that best practice is maintained in the content of the assessment letters to GPs would be advisable.

5.19 The brevity and sparseness of clinical documentation within the GP practice records has already been commented upon and the impact this would have on continuity of care for the patient. However, it is worth highlighting that the IRIS project mentioned at 5.11 in addition to training has devised a system for flagging the electronic records of a patient who has been identified as experiencing domestic abuse on the electronic record. This not only assists with internal identification between GPs, but alerts them to the need for additional care with confidentiality and security.

5.20 Mrs A told the link worker that her self esteem had been destroyed, however there was no follow-up information documented within GP records to identify how this was resolved or improved. There are no details of the intervention. From the records it could be assumed that this issue was not addressed or explored further, and this would have had an impact upon Mrs A's depression and anxiety, and the GP's ability to fully assess his patient's progress and treatment.

5.21 No checks were undertaken of PNC or Firearms checks conducted by control centre staff or Officers attending the suspected domestic abuse callout on 9 August 2011, therefore Officers were unaware that shotguns were kept at the address. As mentioned at paragraph 5.8 current IT systems do not ease the smooth retrieval of this information, and in the taking of an emergency call it may not be straightforward to ask a victim if firearms are at the address. Relying on checks later by the Safeguarding Hub runs the risk that information could be gained too late for a future victim's safety, and Officers too could face danger attending an incident without full information, especially in view of the high number of licensed shotguns in the county.

5.22 To assess the extent to which agencies relevant policies and procedures were followed, and whether these are up to date and fit for purpose in assisting staff to practice effectively where domestic abuse is present.

5.23 There are currently no domestic abuse policies or protocols in the GP practice, or any developed locally for practices to use as a basis for drafting their own procedures for staff to follow. Guidance has been developed to assist GP's with this task by the Royal College of General Practitioners, IRIS, and CAADA [16] and it would be useful if practices availed themselves of this guidance for their own protocol.

5.24 It has not been possible to assess the policies for Mental Health in place in 2006 to 2007 and their effective use by staff. The Mental Health professional involved with Mrs A at that time is no longer in the service. The CPA assessment introduced in April 2012 does include questions about domestic abuse within the Personal History, Family & Development Background section of the CPA document, a section which is wide ranging in its content. The assessment guidance within the document asks the assessor to

[16] Royal College of General Practitioners, IRIS (Identification & Referral to Improve Safety), CAADA. (2012) *Responding to domestic abuse: Guidance for general practices.* http://www.rcgp.org.uk/clinical-and-research/clinical-resources/~/media/Files/CIRC/Domestic%20Violence/RCGP-Responding%20to%20abuse%20in%20domestic%20violence-January-2013.ashx

include whether behaviour within the service user's relationship has been appropriate and whether there is any history of abuse or violent relationships. Unless the practitioner completing the assessment has had training in domestic abuse they would be unlikely to probe sensitively to find out if there were elements of coercive control and non-violent forms of abuse in addition to physical violence taking place as this is not mentioned in the guidance note. It is good to see that the CPA guidance for this section does include considering risk to children in the family or who visit the family, and it does prompt the assessor to consider MARAC (Policy C90) if domestic abuse is disclosed. However, there is no mention of the DASH risk assessment to inform their own health assessments and which is used along with professional judgement for MARAC referrals. Service User safety, confidentiality, and signposting victims to specialist support agencies are not included in the guidance. The assessment includes a section on carer's views and expectations and it is to be hoped that these are collected separately from the interview with the service user, otherwise questioning the service user about their relationships and possible abuse in the presence of a carer or partner is unlikely to produce a genuine and honest answer. It may be helpful in the review process of this document (due April 2013) to consider breaking down this section of the assessment into more discrete sections of enquiry to encourage more in depth probing whilst maintaining a chronological flow of questions to be covered i.e. from family background to current relationship but in separate sections.

5.25 The Norfolk and Suffolk NHS Foundation Trust which is responsible for the delivery of Mental Health services currently has a domestic abuse policy in draft. This draft policy includes the Trusts commitment to MARAC and the delivery and access to training for staff in the use of the DASH risk assessment. It would be advisable for the Trust to consult with specialist domestic abuse support agencies locally such as Leeway Domestic Abuse Services, and Norfolk and Suffolk domestic abuse coordinators before finalising this policy.

5.26 There is every indication that Officers attending the 999 call in August 2011 followed policies and procedures for investigating a suspected domestic abuse incident. The Officers were unaware of the existence of shotguns in the household at that time, and there was no requirement or practical way to check for a firearms certificate holder at the address in 2011. A change in policy and practice is already underway which is to include an addition to the domestic abuse booklet completed by officers. A section is to be added which compels Officers to mark whether firearms are registered to individuals in the household and if so, they are to inform the Firearms Licensing unit. This is an improvement, but the ability to inform Officers en route to a domestic abuse incident whether weapons are at the address remains an issue.

5.27 Firearms Unit policies will be discussed in the following paragraph which concerns their specific terms of reference.

5.28 The Police to examine whether procedures were followed, additional information sought from all Police data systems, and the certificate holder's GP response was received and appropriate to inform the decision to grant continuation of a shotgun certificate to the victim.

5.29 The Firearms Licensing Unit followed their policies and procedures according to the legislation. However, although the discovery of the Police attendance to an alleged domestic abuse incident was discovered in the vetting process it would not have affected the granting of Mrs A's shotgun certificate at that time. A report from the Firearms Unit for this Review indicates that the Enquiry Officer visiting Mrs A had been informed of the incident, but there is no indication that at the visit in 2012 this was discussed to ensure that her shotguns were safely secured and the keys were not

available to her husband who was not a certificate holder. Particularly where domestic abuse is suspected extra vigilance and enquiry about the security of a gun cabinet and its contents needs to be investigated. The ability of Mrs A to keep her gun cabinet keys secure and away from Mr B may have been compromised by the effect of his abusive behaviour, or she just did not realise the risk she was facing in the last few days of their relationship and did not consider his access to the keys given the speed with which events happened during the final weekend. Perhaps more emphasis needs to be given to certificate holders that they, and only they, have legal access to the guns, and anyone else in the household will be in breach of gun licensing law if they have access without a certificate themselves. As information provided indicates that the gun cabinet was in Mr B's office and that he had a key, more effort needs to be taken to ensure that the location of all the certificate holder's cabinet keys are checked and are secure.

5.30 As a result of the ACPO guidance issued in February 2013 concerning firearms licensing and domestic abuse incidents and crimes, a protocol between the Safeguarding and Firearms Units was drafted. The Officer assigned to this task liaised with the Firearms Unit and also the control room regarding making checks. The protocol has now been implemented and sets down the expectation that a Safeguarding Case Investigator will check whether a victim or perpetrator has access to firearms, and the Firearms Licensing Officers will contact the Safeguarding Unit and check concerning domestic abuse history at the time of firearms application or renewal. Training in the DASH risk assessment will be delivered to Firearms Unit staff including administrators, and Safeguarding Case Investigators will receive training in the new process and in making the necessary checks. The protocol intends to check on incidents or crimes that are initially assessed as medium or high risk. This case was assessed as standard risk and under the new protocol such a case would still not be checked for firearms licence or shotgun certificate holders unless it was a case reviewed as part of the 10% dip sample of standard risk incidents. This case makes the argument for all standard risk cases being included in checks for firearms, especially as Norfolk has such a high number of certificate holders.

5.31 Norfolk is a large rural county which is in the top three counties in the country for firearms and shotgun certificate holders. These are held for clay shooting and field sports as well as vermin control. There were a total of 26,140 firearms and shotgun licence and certificate holders in 2008-09 the year Mrs A was reassessed, in addition to 1,431 applications. In 2012 when Mrs A had her 5 year assessment for renewal of her certificate there were 1,268 applications. This volume does pose a problem as to the capacity of the Firearms Unit to deal with the information arising from the number of potential domestic abuse incident checks if all domestic abuse incidents required a check for firearms. In theory improvements in database identification of firearms licence and shotgun certificate holders and additional checks linked to domestic abuse enquires could result in the need to remove and revoke an individual's licence or certificate which would generate extra responsibilities for the Unit. Currently the Firearms Unit brings in extra staff at peak renewal times in the year. Due to the new procedures being drafted those responsible for team resources may find it necessary to review staffing levels more regularly to ensure that licence holders' guns are not posing a threat to their owners or others.

5.32 The fact that the GP surgery did not respond to the letter sent to them by the Police is disappointing. The content of the letter sent out by the Police is used nationally and was agreed between ACPO's Firearms and Explosive Licensing Working Group and the British Medical Association. The letter is written in a way which does not specifically require a response if there are no concerns about granting the renewal, if there are any concerns the GP is asked to respond within 14 days. To assist in assessing whether an individual is suitable to hold a firearm or shotgun certificate this procedure appears to lack rigour

considering how dangerous such a weapon can be in the wrong hands. There is a strong case for a more robust system of assessment. This would undoubtedly require amendments to existing legislation. There are reasonable suggestions that an applicant for a shotgun certificate or firearms licence should undergo a medical on initial application and renewal of their licence. This is similar to the system required by those who are licensed to drive heavy goods vehicles, or hold a motor racing licence. This would provide a more robust system for which GPs would be paid for their time for undertaking the medical, and the medical itself could be designed to meet the requirements of the licensing assessment.

5.33 The DASH risk assessment does include a question about whether the perpetrator has ever used weapons or objects. It does not specifically cover firearms and the wording cannot be changed. However, it would be wise to ensure that Officers are trained to ask about the possession of firearms within this section of questions.

5.34 To involve the family, friends and if appropriate employers of Mrs A and Mr B. The overview report writer will be responsible for meeting with family, friends and employers to invite their contribution to the DHR.

5.35 The author has received contributions from family of Mrs A and Mr B, and a small number of friends and colleagues. Mrs A's family were involved at the start of the Review process. It has been disappointing that a greater number of those invited to contribute have chosen not to do so.

## 5.36 Summing up the analysis

5.37 There are 3 emerging themes from this Review

5.38 1. Despite suffering abuse for many years why could Mrs A not reveal her experiences to any agency? No one asked her because they had not received training to identify the signs and did not have the confidence to ask. She routinely had her husband with her during appointments or interviews and so could not disclose even had she wanted to. No one thought a man such as her husband with influential connections, a high profile in his local area for doing good, and dedicated to working for his community would be a perpetrator of domestic abuse in private, therefore would she be believed? They lived in an area in which some had a "domestic abuse does not happen here" approach[17]; again would she be believed?

5.39 2. Systemically there appears to be a lack of a culture of giving domestic abuse the priority it needs as a Health and Public Health issue over the years. The different sectors in Health are fragmented and this has been exacerbated by fundamental changes in Health structures which have been taking place in recent times. There is no sense of leadership driving the domestic abuse agenda to achieve joined up policies and integrated pathways both between Health sectors and other agencies despite many years of Department of Health guidance and publications[18] advising Health professionals how to tackle this issue. In addition the independent nature of GP practices appears to set them outside the governance and inter-agency practice structures expected and practiced by other agencies. Hence leadership which can span

[17] Personal communication 13.5.13 with a specialist domestic abuse agency who has tried to achieve distribution of posters and leaflets.

[18] Dept of Health 2000 *Domestic Violence: A resource manual for health care professionals.* Dept of Health 2005 *Responding to domestic abuse: a handbook for health professionals.* Dept of Health 2011 *Commissioning services for women and children who experience violence and abuse: a guide for health commissioners*

the different sectors in Health to improve the identification of domestic abuse and support given to victims is vital.

5.40 3. Why was Mr B able to access his wife's gun and kill her? She was the certificate holder, but clearly he knew where the keys were and could gain entry to the gun cabinet, it has also been suggested that he had a key himself. Was this because she was careless with the location of the keys, or did he force her to keep them in a place which was accessible to him or to give him a key? When the Firearms Enquiry Officer first assessed Mrs A for a certificate in June 2007 she appeared "knowledgeable and safety conscious". Other domestic abuse shootings and this Review have revealed the liberal nature of the laws and regulations in place for the granting of a shotgun certificate; there was nothing to prevent Mrs A being granted a shotgun certificate. Even the domestic abuse incident was not enough to enable the Police to refuse the certificate renewal. Had it been revoked following that incident the guns would not have been in the house for Mr B to use to kill his wife, but equally he could have used another weapon, although using a gun means the perpetrator does not have to be at close quarters to his victim unlike a death by stabbing or strangulation.

5.41 Reducing hindsight bias

5.42 The author and Review Panel have made every effort to view the actions taken by agencies and individuals in this case through the lens of practice and policies and procedures in place at the time. Domestic abuse awareness and resources have changed over time and we have been mindful of this when assessing what are reasonable expectations of staff and agencies in their handling of this case.

# 6 Conclusions:

6.1 A primary purpose of the Domestic Homicide Review in addition to identifying actions taken and lessons to be learnt is to determine whether the homicide was predictable and preventable. The information available to agencies at the time of the fatal incident would not have enabled them to predict the terrible event which led to Mrs A's death. That Mrs A had experienced domestic abuse for many years at the hands of her husband was unknown to them. His public persona and high standing in the community may also have made it unthinkable that he was abusing Mrs A in the privacy of their own home, and indeed there is still incredulity in some quarters that Mr B shot Mrs A and then took his own life.

6.2 There is evidence to suggest that Mr B planned to shoot Mrs A on the day she returned to the couple's home to discuss their future. He had laid out the couple's Wills and left instructions for his funeral. It is likely that he had obtained the shotgun from the gun cabinet before she arrived, for if she had seen him get the keys and go to the cabinet she may well have had the time to escape to a safe distance. Agencies could not have prevented her death that day.

6.3 Unknown to Mrs A was the fact that high up the risk assessment scale for the risk of serious harm or homicide in domestic abuse cases is the time of separation and leaving a relationship. The fact that she was finally contemplating leaving Mr B took her into this high risk category.

6.4 If Mrs A been supported to disclose the abuse she was suffering to professionals and they and the friends she had disclosed to had had information about domestic abuse, the risks faced by victims, and where to go for support, there is a chance she might have been persuaded to accessed this help and safely separate from Mr B.

6.5 Lessons to be learnt

6.6 One of the main lessons to be learnt by professionals from this case is the need to suspend all disbelief that a person who is high profile and seen as doing good in their community cannot be a perpetrator of domestic abuse. Domestic abuse takes place in all stratus of society. It is possible that Mrs A had come to not only accept her way of life, but the position her husband held may have put addition pressure on her not to seek help. This emphasises even more sharply the importance of a wide range of professionals having knowledge about domestic abuse which enables them to recognise signs and symptoms which may indicate abuse is taking place, and to be able to help a victim to disclose their experiences safely and be referred on for specialist support. Health professionals in particular are often viewed by their patients as someone they can trust and confide in, but circumstances need to be created which enable them to do this with confidence and safety, and professionals need to be equipped with the skills to act appropriately.

6.7 Strategic level leadership is needed to drive forward the domestic abuse agenda in the county across all agencies, but particularly in Health and Public Health. Staff need not only the policies and procedures to guide their practice, they need training and to work in an atmosphere of supportive supervision for the risk assessments they have to make and the decisions they take. A culture of inter-agency working across statutory and specialist voluntary sector organisations should prevail.

6.8 Victims need to be given a safe and confidential space on their own with Health professionals so that they have the opportunity to disclose domestic abuse if they wish. It is particularly important that they are seen alone for assessments, where the patient is suffering from depression, or where research may suggest possible health or ill-health indicators of abuse.

6.9 Interviews undertaken by the Police and the Review author reveal that Mrs A had disclosed to some friends that she had been abused by Mr B for some years, however apart from the 2011 incident when she called the Police no other reports of abuse had been reported to them. This is not unusual; as highlighted in paragraph 5.8 research shows that women can experience up to 35 assaults before calling the Police, therefore it is important that domestic abuse incidents are seen in this context. A victim in Mrs A's position would probably not have felt able to disclose the assault she suffered with her husband in the house, albeit Officers acted according to best practice in interviewing them separately. Even though it is routine practice to provide support telephone numbers and information to a victim when attending an incident, a follow-up phone call at a safe time when the perpetrator is not present would be an additional act of best practice, most particularly when alcohol has been consumed and the victim may not have taken in all that was said to them.

6.10 Assessing only the person who is to be the firearms licence or shotgun certificate holder when considering the granting of a gun certificate does not in itself limit the risk of a gun being misused. This case demonstrates that there is a great deal of trust placed in the applicant to ensure that others in the household do not have access to the weapon and ammunition to use it. Mr B knew where the keys were to the gun cabinet and had access. By this fact he too should have been assessed to be granted a gun certificate. One might argue that gun legislation is still too liberal and Chief Officers have little

discretion to refuse to grant a license. There is a strong argument for a more robust approach to assessments for granting and renewing licences and certificates.

6.11 There is a tendency to think that domestic abuse does not happen in affluent areas, and it does not happen in relationships such as Mrs A's and Mr B's. Yes, the couple had good times together, but this was interrupted by incidents of abuse over the years. This case graphically demonstrates how the public face of an individual can be very different to the one behind closed doors. Abuse does not just happen in relationships in a certain sector of society. It is taking place in rural and urban areas, deprived and affluent areas, and across all ages and backgrounds. The phrase "it doesn't happen here" needs to be dispelled and information needs to be available across the county for professionals, families, friends and colleagues to help them identify domestic abuse, what constitutes increasing risk to victims, and where to go for help.

# 7 Recommendations

7.1 These recommendations have been informed by the Independent Management Reviews and the Overview Report writer's assessment. A number of the recommendations relate to the clinical management of a patient's care rather than specifically to domestic abuse, but they are included here for the benefit of additional learning for those working in the relevant agencies.

National level:

7.2 **1.** That NHS England build into its contractual and performance management arrangements a requirement that GP practices should implement the Identification and Referral to Improve Safety (IRIS) system in coordination with Independent Domestic Violence Advocacy Services[19].

7.3 **2.** That NHS England support primary care services to be more aware of their responsibilities to share relevant information which is required to ensure the safety of their patients and members of the public.

7.4 **3.** That there is a national review of the Firearms (Amendment) Act 1997 Section 37 (26B) Applications for shot gun certificates, to include the criteria by which an individual is granted a shotgun certificate. Such criteria should include:

(a) A definition of a 'fit and proper person' appropriate for being granted a certificate or licence and that it is not a person's right to have a shotgun certificate, but that they have to demonstrate they are a fit and proper person to be granted a certificate.

(b) A requirement to have a medical before the granting and renewal of a shotgun certificate paid for by the applicant. No certificate should be granted before a satisfactory medical is received, and the onus is on the applicant to ensure that this is received by the Firearms Licensing Department in the time required.

(c) The checking of Police records and risk assessment of members of the household of applicants.

[19] Howell A, & Johnson M (2011) *IRIS Identification & Referral to Improve Safety: The IRIS solution – responding to domestic violence and abuse in general practice*. University of Bristol http://www.irisdomesticviolence.org.uk/holding/IRIS_Commissioning_Guidance.pdf

(d) The prohibition of the granting or renewal of a certificate where the applicant or associated person/s has involvement or association with violence or domestic abuse.

(e) Whilst gun security is already in the regulations this should be given greater prominence in the declaration so that the certificate holder is clear of their responsibilities to ensure that gun cabinet keys are separately secured and not available to anyone else in the household who is not also a certificate holder. Confirmation of the keys secure location should be part of the inspection process. Failure to comply with this regulation should be an offence, and unlawfully accessing the keys by a third party should be an offence.

NB Please see section 8 page 34 for additional information which was published by the Home Office concerning revised Guidance for Firearms legislation after this Review was completed which relates to this recommendation.

National and County level:

7.5 **4.** Training for Health professionals including Mental Health, GPs, and other primary care staff should include mandatory training about domestic abuse separate from safeguarding training. This training should be a rolling programme to encompass new staff and be commenced within 6 months of the publication of this Review. It should include:

(a) The identification of domestic abuse, risk assessment, how to engage with patients who may be at risk by being able to ask questions safely and sensitively, and knowledge of specialist support agencies to whom they can refer.

(b) An awareness of the evidence base, health markers, and links between domestic abuse and depression, and other medical conditions;

(c) An awareness of domestic abuse perpetrator profiles to assist in the identification of high risk behaviours and when and to whom to provide information should a patient's behaviour cause risk to others. Knowledge of support for perpetrators who wish to change their behaviour should be included and referral routes.

7.6 **5.** That all Health agencies and GP practices develop domestic abuse policies and protocols within 1 year of the publication of this Review which clearly outline the responsibilities of staff to understand and respond to the needs of domestic abuse victims. The policies and protocols should be mindful of the Home Office definition of domestic abuse which was amended in March 2013[20] to include individuals of 16 years and over, and the inclusion of coercive control in the description of abuse. Policies and protocols should include:

(a) A domestic abuse care pathway as recommended by the Royal College of General Practitioners, IRIS, and CAADA: this can be found at http://www.rcgp.org.uk/clinical-and-research/clinical-resources/domestic-violence.aspx

(b) The identification of a key individual within the agency or practice who will have additional training and be able to act as more specialist support for other staff.

(c) Where an individual is regularly accompanied by a partner, relative or carer a policy should be put in place setting a clear expectation that opportunities will be made

[20] www.gov.uk/domestic-violence-and-abuse

available to see individuals alone in a safe and confidential setting. Advice and guidance on how to achieve this should be included.

(d) At the time of writing NICE are in the process of developing guidance to support the prevention and reduction of domestic violence which is due to be published in February 2014. It is proposed that Clinical Commissioning Groups take forward NICE recommendations with its membership at that point.

7.7 **6.** GPs would find it useful to access the Royal College of General Practitioners e-learning course for guidance and practice advice regarding domestic violence. This is available on the Royal College's website at: http://elearning.rcgp.org.uk (enter domestic violence in the search for courses window).

NB Please see section 8 page 34 for additional information which was published by NICE after this Review was completed and which relates to the Health recommendation.

**County level:**

7.8 **7.** That the Director of Public Health and a leading Practitioner for the county Clinical Commissioning Groups provide leadership to drive forward Health's contribution to an integrated multi-agency domestic abuse strategy for the whole county by June 2014.

7.9 **8.** Information about domestic abuse, helplines, and routes to support locally and nationally should be provided for victims, family members, friends and work colleagues. This information should be widely available in a variety of venues throughout rural and urban communities. The information should include identifying the signs of domestic abuse, what constitutes increased risk to victims, and where to go for help. It should be available in a variety of formats, including a size which can be easily given discretely and safely to victims at the time of an incident, consultation, or disclosure to a friend. The materials should be available and displayed across the county by January 2014.

7.10 **9.** GP Practices should provide a protocol for staff involved in patient care by December 2013 which clarifies expectations relating to written record keeping and the maintenance of electronic records which should provide a high level of detail and information pertaining to the treatment and assessment of patients; include the rationale for decisions making; outlines what is offered to patients along with reasons for options being declined, but most importantly offers a clear chronological account of care provided.

7.11 **10.** The following are recommended when assessing and monitoring patients suffering from longstanding depression and should be disseminated throughout GP practices and Mental Health providers and commissioners by December 2013:

(a) NICE Guidance[21] is available to support the management of Depression in Adults and Depression in Adults with Chronic health problems and should be utilised as this provides a clear, structured and tested framework. If there is variance to the guidance a rationale for decision making should be documented within a patient's clinical records to clarify choices and options made.

(b) A clear risk assessment process should be undertaken for patients with depression which gauges the behaviour of a patient and determines how they may react to various

[21] National Institute for Clinical Excellence (NICE) Guidance (CG91 2009 Treatment of Depression in Adults with Chronic Health Problems and Depression in Adults updated 2009)

methods of treatment. It should identify the level of depression and identify any suicidal ideation; this is clearly stated within NICE Guidance. Treatment options and onward referral should be structured to fit appropriately with the patient's level of need determined from risks assessed. For example where depression and substance misuse are found to coexist a coordinated treatment plan addressing both conditions should be explored.

(c) Where treatment of depression is being managed between primary care and mental health community or secondary care services, information should be complete and accurate, providing a clear chronology of case management activity, treatment and actions taken through the duration of input. The GP is always a central professional in sustaining care for an individual and therefore must be in receipt of all information that will allow them to effectively manage and consider patients future needs.

7.12 **11.** The Community Safety Partnership should monitor the progress and impact of the protocol between the Safeguarding and Firearms Units introduced in mid 2013 concerning domestic abuse and checking firearms databases to ensure that it is able to be implemented effectively in practice. The Partnership may wish to be made aware on an annual basis of the effect of this policy vis a vis the number of licences or shotgun certificates revoked due to incidents of domestic abuse.

7.13 **12.** The Community Safety Partnership should support and monitor the implementation of domestic abuse policies within Health partner agencies and give appropriate 'expert' guidance from board partners from the specialist domestic abuse sector to ensure that policies meet the needs and safety requirements of victims and survivors of domestic abuse.

7.14 **13.** Information sharing protocols should be reviewed to ensure that all agencies have appropriate agreements in place for the timely and accurate sharing of information. This is particularly the case for the sectors within Health and Mental Health who have undergone radical restructuring in recent months. This should be completed by October 2013. Any necessary amendments to protocols should be completed by January 2014.

7.15 **14.** The Police should ensure that all frontline Officers and the relevant support staff complete training in the DASH risk assessment, its use with victims and the evidence base behind the risk factors. Training should include ensuring that firearms are included when asking questions about weapons.

7.16 **15.** Where a victim is found to be under the influence of alcohol or other substances at the time of investigating an alleged incident of domestic abuse, a call should be made the following day, or as soon as practicable, to follow-up the incident and to provide advice when the victim is unaffected by substances and the perpetrator is not present.

## 8.0 Additional information received after completion of the Review

8.1 In August 2013 the Home Office published the Guide on Firearms Licensing Law[22]. This Guide revises previous guidance and includes specific instructions where domestic abuse is known or suspected in the household of a firearm or shotgun certificate holder. Chapter 12 paragraph 12.40 stipulates that following any incident of domestic violence or abuse a review should take place as to the continued suitability of the certificate holder.
The guidance also includes the following:

[22] https://www.gov.uk/government/news/new-firearms-guidance-on-domestic-violence-published

- When police officers receive information about an applicant having a history of domestic violence, they should consider interviewing their family, friends and associates.
- Speaking to the applicant's partner – who might be a victim of abuse – may be judged to be "essential".
- The information the partner gives must be treated confidentially and police would need to take steps to make sure they are safe from possible reprisals.
- The partner would not have to approve an application for a firearms certificate – that responsibility would still lie with the police, who would also consult their own force's domestic violence unit.

The guidance also confirms that the police would not have to rely on a criminal conviction for domestic violence when considering applications. They would be able to consider police intelligence about an incident, looking at how recent it was and whether it was isolated behaviour or part of a pattern. This Guidance is welcome and goes some way to improving safety for those experiencing domestic abuse, however, it makes the assumption that the perpetrator of abuse is always the certificate holder whereas the victim was the certificate holder in this tragic case. This Review recommendation that the medical process and confirmation on suitability by GP's be strengthen has not yet been adequately addressed in the revised Guidance.

8.2 At the beginning of August 2013 the National Institute for Health and Care Excellence issued a draft Public Health Guidance for consultation. Domestic Violence & Abuse: how social care, health services and those they work with can identify, prevent and reduce domestic violence and abuse[23] makes 17 recommendations for changes within Health and social care. A number of the recommendations made in this Review are also recommendations within this Guidance. This includes a call for an integrated care pathway for identifying, referring and providing support to those experiencing domestic abuse and those perpetrating it. A further recommendation advocates the creation of an environment for those affected to disclose domestic abuse, and includes the need to display information in various formats. Encouragingly, the draft Guidance also recommends training for all levels of staff from GPs to reception staff, and the inclusion of domestic abuse in pre-qualifying and continuing professional development for Health and social care professionals. If this Guidance is adopted and implemented many of the Health recommendations in this Review would be met.

[23] http://www.nice.org.uk/guidance/index.jsp?action=download&o=64783

**APPENDIX A**

Home Office

**Violent Crime Unit**
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Ms Laura McGillivray
Chair of Norfolk County Community Safety Partnership
City Hall
Norwich
NR2 1NH

23 August 2013

Dear Ms McGillivray,

Thank you for submitting the report from Norfolk to the Home Office Quality Assurance (QA) Panel. The review was considered at the QA Panel meeting in August as agreed.

The QA Panel would like to thank you for conducting this review and for providing them with the covering letter, overview report, action plan and executive summary. 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.

There are a few issues that the QA Panel felt would benefit from consideration before you publish the final report:

- Consider including a reference to substance misuse in recommendation 10(b);
- Removal of the personal information on the victim and the perpetrator from the direct quotes from the diary notes of the victim;
- Update the sections relating to health recommendations and gun control given the recent publications in respect of their interface with domestic violence cases;
- Attempting to further anonymise the report as all identifiable references including the date of death, should be removed in order to protect identities and comply with the Data Protection Act 1998, in accordance with paragraph 9.2 of the Statutory Guidance for the Conduct of Domestic Homicide Reviews.

The QA Panel would like to commend you on the following that were considered to have been done very well:

- The report was thorough, well written and demonstrated a clear understanding of the dynamics of domestic abuse;
- The report clearly draws on the information provided in the IMRs, and lessons learnt appropriately link to, and emerge from, the analysis of the information provided;
- Given that not all family members were aware of the nature of the relationship between the victim and the perpetrator the author has handled the presentation of this information with care and sensitivity; and
- Despite very limited agency contact, the Chair has conducted a thorough investigation to extract all useful learning in this DHR.

The QA Panel does not need to see another version of the report, but I would ask you to include this letter as an appendix to the report when it is published.

Yours sincerely,

Mark Cooper, Chair of the Home Office Quality Assurance Panel
Head of the Violent Crime Unit

**APPENDIX B**

| RECOMMENDATION | Scope of recommendation i.e. local or regional | Action to be taken | Lead Agency | Key milestones/ Progress RAG Rating | Target date | Date of completion and Outcome |
|---|---|---|---|---|---|---|
| *What is the over-arching recommendation?* | *Should this recommendation be enacted at a local or regional level? (N.B national learning will be identified by the Home Office Quality Assurance Group however the review panel can suggest recommendations for national level* | *How exactly is the relevant agency going to make this recommendation happen? What actions need to occur?* | Lead Officer /Head of Service to report progress to CCSP quarterly | On Target<br>Below Target but acceptable level<br>Worse than Target unacceptable level | | |
| **1.** That NHS England build into its contractual and performance management arrangements a requirement that GP practices should implement the Identification and Referral to Improve Safety (IRIS) system in coordination with Independent Domestic Violence Advocacy Services[24]. | **National** | To be added to contracts for independent contractors which includes GPs, dentists etc. | NHS England | Negotiation and agreement of standard clause.<br><br>Inclusion in next round of contract negotiations. | April 2014 | GPs and Health professionals are able to identify and support victims of domestic abuse effectively and safely. |

[24] Howell A, & Johnson M (2011) *IRIS Identification & Referral to Improve Safety: The IRIS solution – responding to domestic violence and abuse in general practice*. University of Bristol
http://www.irisdomesticviolence.org.uk/holding/IRIS_Commissioning_Guidance.pdf

| RECOMMENDATION | Scope of recommendation i.e. local or regional | Action to be taken | Lead Agency | Key milestones/ Progress RAG Rating | Target date | Date of completion and Outcome |
|---|---|---|---|---|---|---|
| **2.** That NHS England support primary care services to be more aware of their responsibilities to share relevant information which is required to ensure the safety of their patients and members of the public. | | Clear contracted agreements need to be written regarding guidance around sharing of information where domestic abuse is suspected or identified | NHS England | Contract negotiations<br><br>Completed negotiations<br><br>Contract drawn up and approved<br><br>Contracts to be sent out for signing and returned | April 2014 | GPs and other health professionals clear about their responsibilities to share information appropriately, proportionately and safely concerning patients experiencing and perpetrating domestic abuse.<br><br>GPs aware of their responsibilities to share information with police firearms licensing departments |
| **3.** That there is a national review of the Firearms (Amendment) Act 1997 Section 37 (26B) Applications for shot gun certificates, to include the criteria by which an individual is granted a shotgun certificate. Such criteria should include:<br>(a) a definition of a 'fit and proper person' appropriate for being granted a certificate or licence and that it is not a person's right to have a shotgun certificate, but that they have to demonstrate they are a fit and proper person to be granted a certificate.<br>(b) a requirement to have a medical before the granting and renewal of a | **National** | Local Action to support this recommendation: Norfolk Chief Officers Team to consider writing to ACPO nationally to raise the issue and to contribute to any national consultations. | Norfolk Police | | | Improved safe keeping of shotguns and reduction in their misuse. |

| RECOMMENDATION | Scope of recommendation i.e. local or regional | Action to be taken | Lead Agency | Key milestones/ Progress RAG Rating | Target date | Date of completion and Outcome |
|---|---|---|---|---|---|---|
| shotgun certificate paid for by the applicant. No certificate should be granted before a satisfactory medical is received, and the onus is on the applicant to ensure that this is received by the Firearms Licensing Department in the time required.<br>(c) the checking of Police records and risk assessment of members of the household of applicants.<br>(d) the prohibition of the granting or renewal of a certificate where the applicant or associated person/s has involvement or association with violence or domestic abuse.<br>(e) whilst gun security is already in the regulations this should be given greater prominence in the declaration so that the certificate holder is clear of their responsibilities to ensure that gun cabinet keys are separately secured and not available to anyone else in the household who is not also a certificate holder. Confirmation of the keys secure location should be part of the inspection process. Failure to comply with this regulation should be an offence, and unlawfully accessing the keys by a third party should be an offence. | | | | | | |
| **4.** Training for Health professionals including Mental Health, GPs, and other primary care staff should include mandatory training about | **National & County** | **National**<br>Department of Health to take forward competency based training for the sector | Dept of Health | | | Health staff will have a clear understanding of Domestic Abuse, its |

| RECOMMENDATION | Scope of recommendation i.e. local or regional | Action to be taken | Lead Agency | Key milestones/ Progress RAG Rating | Target date | Date of completion and Outcome |
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| domestic abuse separate from safeguarding training. This training should be a rolling programme to encompass new staff and be commenced within 6 months of the publication of this Review. It should include:<br><br>(a) The identification of domestic abuse, risk assessment, how to engage with patients who may be at risk by being able to ask questions safely and sensitively, and knowledge of specialist support agencies to whom they can refer.<br><br>(b) An awareness of the evidence base, health markers, and links between domestic abuse and depression, and other medical conditions;<br><br>(c) An awareness of domestic abuse perpetrator profiles to assist in the identification of high risk behaviours and when and to whom to inform should a patient's behaviour cause risk to others. Knowledge of support for perpetrators who wish to change their behaviour should be included and referral routes. | | **County**<br>CCG's and NHS England to agree an expectation for training to be undertaken which will educate patient facing staff to be able to identify individuals at risk of/or experiencing domestic abuse and enable the signposting/referral to appropriate specialist services<br><br>a)b)c) That the Countywide Domestic Abuse & Sexual Violence Board (DASV) develop a cohesive training pack based upon standard competencies of basic awareness training for domestic abuse and more specifically will highlight health related markers to provide risk indicators of domestic abuse for their patients | CCG<br>NHS England<br><br>DASVB | DASVB training group reviews current training and undertakes training needs assessment.<br><br>Rolling programme of regular basic awareness and in depth training planned and delivered. | By April 2014<br><br>By Jan 2014 | triggers and effects on their patient group and how to access support and advice for them.<br><br>There will be accessible competency based training available for staff within the county on domestic abuse |
| **5.** That all Health agencies and GP practices develop domestic abuse policies and protocols within 1 year of the publication of this Review which clearly outline the | **County** | That policy is developed which interlinks with the countywide integrated strategy for identification and management of domestic violence (to cross | | DASVB agrees the process and working group for developing an integrated strategy | By Sept 14 | That health agencies and GP practices have clear processes for the management and |

| RECOMMENDATION | Scope of recommendation i.e. local or regional | Action to be taken | Lead Agency | Key milestones/ Progress RAG Rating | Target date | Date of completion and Outcome |
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| responsibilities of staff to understand and respond to the needs of domestic abuse victims. The policies and protocols should be mindful of the Home Office definition of domestic abuse which was amended in March 2013[25] to include individuals of 16 years and over, and the inclusion of coercive control in the description of abuse. Policies and protocols should include:<br><br>(a) A domestic abuse care pathway as recommended by the Royal College of General Practitioners, IRIS, and CAADA.<br><br>(b) The identification of a key individual within the agency or practice who will have additional training and be able to act as more specialist support for other staff.<br><br>(c) Where an individual is regularly accompanied by a partner, relative or carer a protocol should be put in place setting a clear expectation that opportunities will be made available to see individuals alone in a safe and confidential setting. Advice and guidance on how to achieve this should be included.<br><br>(d) At the time of writing NICE are | | reference with recommendation 7)<br><br>There is a contractual requirement for Health providers and GP practices to have localised policies and systems in place which takes into account the revised definition of domestic abuse.<br><br>a) That GPs consult the Royal College of General Practitioners to support the development of a local care pathway for their practice population to enable signposting and referral to specialist services and support.<br><br>b) Health agencies to identify a key individual with additional training and awareness of Domestic abuse who will act as a resource and support for other staff.<br><br>c) As part of the Care Pathway to establish the identification of individuals who might meet health triggers for domestic violence which is identified through domestic abuse training and a process which will enable them to consult with the individual on their own. | By April 2014 | for the identification and management of Domestic abuse.<br><br>Strategy to be completed and approved by Board Dec 14<br><br>Strategy to be shared with GP practices by End Jan 14<br><br>Commissioners of health services develop the requirement for Domestic abuse lead and pathway within commissioning intentions and contracts.<br>April 14 | | support of patients at risk or experiencing Domestic Abuse which includes a standardised care pathway and identified route of expertise for staff. |

[25] www.gov.uk/domestic-violence-and-abuse

| RECOMMENDATION | Scope of recommendation i.e. local or regional | Action to be taken | Lead Agency | Key milestones/ Progress RAG Rating | Target date | Date of completion and Outcome |
|---|---|---|---|---|---|---|
| in the process of developing guidance to support the prevention and reduction of domestic violence which is due to be published in February 2014. It is proposed that Clinical Commissioning Groups take forward NICE recommendations with its membership at that point. | | d) That NICE Guidance is taken forward to be used as a basis for managing Domestic Abuse within General practice once it has been issued | | | | GP Practices are made aware of and follow relevant NICE Guidance April14 |
| **6.** GPs would find it useful to access the Royal College of General Practitioners e-learning course for guidance and practice advice regarding domestic violence. This is available on the Royal College's website at: http://elearning.rcgp.org.uk (enter domestic violence in the search for courses window). | **National & County** | CCG's and NHS England to raise awareness to practices of this online learning tool | CCG's<br><br>NHS England | CCG's to confirm to Norfolk County Community Safety Partnership (NCCSP) that information and link is circulated to GPs | | GP's can readily access appropriate e-learning and improve their knowledge of domestic abuse thus provide appropriate support, signposting or referral to specialist agencies. |
| **7.** That the Director of Public Health and a lead representative for the county Clinical Commissioning Groups provide leadership to drive forward Health's contribution to an integrated multi-agency domestic abuse strategy for the whole county by June 2014. | **County** | DASVB to identify key individuals and process to take forward the development of a strategic countywide integrated domestic abuse strategy along with a plan for dissemination and action by all agencies | Public Health CCG DASVB | Strategy Group formed. Strategy Drafted and Consultation takes place.<br>Amend & DASVB agree strategy.<br>Strategy agreed by NCCSP and published.<br>Strategy implementation monitored by NCCSP | July '13<br><br>Sept '13<br><br>Oct '13<br><br>Oct '13 | Completed and disseminated countywide strategy implemented and acted upon to improve joined up services |
| **8.** Information about domestic abuse, helplines and routes to support locally and nationally should be provided for victims, family | **County** | Discrete information leaflet has been produced by Police<br><br>Leeway Domestic Abuse Services | Police<br><br>Leeway Domestic | Leaflet at printers, & delivery due<br><br>Distribute materials to | July 2013<br><br>Sept | By March 2013 victims, family, friends & colleagues across |

| RECOMMENDATION | Scope of recommendation i.e. local or regional | Action to be taken | Lead Agency | Key milestones/ Progress RAG Rating | Target date | Date of completion and Outcome |
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| members, friends and work colleagues. This information should be widely available in a variety of venues throughout rural and urban communities. The information should include identifying the signs of domestic abuse, what constitutes increased risk to victims, and where to go for help. It should be available in a variety of formats, including a size which can be easily given discretely and safely to victims at the time of an incident, consultation, or disclosure to a friend. The materials should be available and displayed across the county by January 2014. | | already has posters and leaflets<br><br>GP practices display posters & leaflets & have leaflets in consultation rooms to give to patients as required.<br><br>Develop, consult & put into action a county wide communications plan: variety of media-social networking sites etc.<br><br>Action by partners to disseminate as widely as possible information to reach victims, family members and work colleagues<br><br>Carry out a white ribbon campaign | Abuse Services<br><br>GP Practices<br><br>DA & SV coordinator in consultation with DASVB<br><br>Multi agency<br><br>DASVB sub group | all GP practices within county<br><br>GP Practices confirm to Leeway that materials are displayed & available<br><br>Production of plan & draft to CCSP<br><br>Production and distribution of materials<br><br>Planning group meeting July 2013 | 2013<br><br>Oct 2013<br><br>Oct 2013<br><br>From Jan 2014<br><br>Nov 2013 | the county will better informed about routes to support and risks associated with domestic abuse. |
| **9.** GP Practices should provide a protocol for staff involved in patient care by December 2013 which clarifies expectations relating to written record keeping and the maintenance of electronic records which should provide a high level of detail and information pertaining to the treatment and assessment of patients; include the rationale for decision making; outlines what is offered to patients along with reasons for options being declined, but most importantly offers a clear chronological account of care | **County** | Practices to develop agreed standards of documentation which can be applied to practice records and monitored to ensure continuity of care and rationale for clinical decision making | GP Practices | Feedback and outcomes from the report to be shared with practices by Dec 13 | | Clear expectations to practice staff regarding minimum standards of documentation that are required and a process by which to monitor them<br>Dec 13 |

| RECOMMENDATION | Scope of recommendation i.e. local or regional | Action to be taken | Lead Agency | Key milestones/ Progress RAG Rating | Target date | Date of completion and Outcome |
|---|---|---|---|---|---|---|
| provided. | | | | | | |
| **10.** The following are recommended when assessing and monitoring patients suffering from longstanding depression and should be disseminated throughout GP practices and Mental Health by December 2013:<br><br>(a) NICE Guidance[26] is available to support the management of Depression in Adults and Depression in Adults with Chronic health problems and should be utilised as this provides a clear, structured and tested framework. If there is variance to the guidance a rationale for decision making should be documented within a patient's clinical records to clarify choices and options made.<br><br>(b) A clear risk assessment process should be undertaken for patients with depression which gauges the behaviour of a patient and determines how they may react to various methods of treatment. It should identify the level of depression and identify any suicidal ideation; this is clearly stated within NICE Guidance. | **County** | Local practices:<br><br>a) Practices agree how, they as a team, will work to deliver best practice options for their patients which are linked to NICE Guidance or alternative clinically justifiable plans. These agreements form part of practice process and can be called into account by practice members.<br><br>b) Practices agree and identify a validated risk assessment tool which can be used to assess patients and their level of risk when presenting with depression i.e HADS tool<br><br>c) That mental health agencies | Health<br>NHS CB<br>CCG's<br><br>GP Practices<br><br>GP Practices | Feedback and learning to be cascaded to practices with recommendations for actions by Dec 13 | | Professionals clear about best practice options and decision making to support patients with their management of depression and risk factors are identified where possible and managed appropriately. |

[26] National Institute for Clinical Excellence (NICE) Guidance (CG91 2009 Treatment of Depression in Adults with Chronic Health Problems and Depression in Adults updated 2009)

| RECOMMENDATION | Scope of recommendation i.e. local or regional | Action to be taken | Lead Agency | Key milestones/ Progress RAG Rating | Target date | Date of completion and Outcome |
|---|---|---|---|---|---|---|
| Treatment options and onward referral should be structured to fit appropriately with the patient's level of need determined from risks assessed.<br><br>(c) Where treatment of depression is being managed between primary care and mental health community or secondary care services, information should be complete and accurate, providing a clear chronology of case management activity, treatment and actions taken through the duration of input. The GP is always a central professional in sustaining care for an individual and therefore must be in receipt of all information that will allow them to effectively manage and consider patients future needs. | | who are involved with patients must provide full and detailed feedback and discharge summary to GP's outlining:<br>• Treatment provided<br>• Risks outstanding<br>• Med management plans<br>• Specific concerns which might relate to patients safety or wellbeing<br>• Any issues relating to Domestic abuse | Mental Health Trust | | | A clear, detailed and robust process of handover and communication to support on-going treatment of patients<br><br>Dec 13 |
| **11.** The Community Safety Partnership should monitor the implementation of revised protocols within the Police concerning domestic abuse and checking firearms databases to ensure that it is able to be implemented effectively in practice. Formalisation of the new protocol should be achieved as soon as possible, but no later than October 2013. The Partnership may wish to be made aware on an annual basis of the effect of this policy vis-a-vis the number of licences revoked due to incidents of domestic abuse. | **County** | Process already in operation as from May 2013.<br><br>Written protocol and flowchart detailing the process to be formalised and circulated<br><br>Produce annual report for CSP re number of licences revoked due to Domestic Abuse | Police | As per target date<br><br>Protocol & flowchart confirmed to CSP as completed & circulated | May 2013<br><br>Oct 2013<br><br>Oct 2014 | Improve clarity for officers and for safety of both parties.<br><br>Ensure robust monitoring around the issuing and renewals of firearms licences to those involved with violence |

| RECOMMENDATION | Scope of recommendation i.e. local or regional | Action to be taken | Lead Agency | Key milestones/ Progress RAG Rating | Target date | Date of completion and Outcome |
|---|---|---|---|---|---|---|
| **12.** The Community Safety Partnership should support and monitor the implementation of domestic abuse policies within Health partner agencies and give appropriate 'expert' guidance from board partners from the specialist domestic abuse sector to ensure that policies meet the needs and safety requirements of victims and survivors of domestic abuse. | **County** | Agencies to consult with the DASVB Workplace Policies sub group before finalising their policy to ensure integration and best practice across the county | Multi agency and DASVB workplace policy group | As and when required | From July 2013 | Expert guidance available and effective integrated policies available to guide staff |
| **13.** Information sharing protocols should be reviewed to ensure that all agencies have appropriate agreements in place for the timely and accurate sharing of information. This is particularly the case for the sectors within Health and Mental Health who have undergone radical restructuring in recent months. This should be completed by October 2013. Any necessary amendments to protocols should be completed by January 2014. | **County** | Reinforce clear expectation and support to professionals to assist them to identify how to share information appropriately and relevantly in the interests of patients who might be at risk of harm.<br><br>The requirements of good information sharing should be included within training standards.<br><br>Identify key individuals within agencies who can act an expert resource for advice on information sharing issues. | All Agencies | List of agencies requiring info sharing protocol completed and contact made.<br><br>Agencies review protocols and respond on status of protocols.<br><br>Report status of protocols to CCSP<br><br>Protocols revised and amended by January 2014 and disseminated once agreed | Start of August 13<br><br>By start of Oct 2013<br><br>CCSP Oct 2013 Meeting<br><br>Report to CCSP Jan 2014 | To have a clear and accessible information sharing protocol and a plan to disseminate across relevant workforces to support effective information sharing.<br>January 2014 |
| **14.** The Police should ensure that all frontline Officers and the relevant support staff complete training in the DASH risk assessment, its use with victims and the evidence base behind the risk factors. Training should | **County** | NCCSP to receive a quarterly update on police officers trained and how many are outstanding<br><br>Internal awareness raising via internal communication regarding | Police | Quarterly to CCSP | Commencing Oct 2013 and ongoing | Officers trained and effectively able to risk assess and include questions about possession of firearms to |

| RECOMMENDATION | Scope of recommendation i.e. local or regional | Action to be taken | Lead Agency | Key milestones/ Progress RAG Rating | Target date | Date of completion and Outcome |
|---|---|---|---|---|---|---|
| include ensuring that firearms are included when asking questions about weapons | | the specific question of the access to and location of legally held firearms to be asked when completing the DASH risk assessment, to be included in all training of new officers from now on | | | | complete the risk assessment and comply with ACPO guidance |
| **15.** Where a victim is found to be under the influence of alcohol or other substances at the time of investigating an alleged incident of domestic abuse, a call should be made the following day, or as soon as practicable, to follow-up the incident and to provide advice when the victim is unaffected by substances and the perpetrator is not present. | **County** | Obtain analysis to find out exact numbers of victims this action would relate to who are not currently contacted through existing processes.<br>Understand resourcing implications and provide options in report to Chief Officer Team, Police & Crime Commissioner and CCSP.<br><br>Implementation of option chosen | Police | Report on Stage I to CSP – Oct 2013<br><br>Implementations of option chosen - | Within 12 months from approved option agreed | Victims who are affected by alcohol or substances are able to be better informed and understand any risks they may face |