east sussex safer communities partnership

DOMESTIC HOMICIDE REVIEW (DHR)

Executive Summary

SIGNIFICANT INCIDENT LEARNING PROCESS

Subject: Deborah
Month of Death: July 2020

SILP™ SIGNIFICANT INCIDENT LEARNING PROCESS

Independent Chair: Donna Ohdedar
Author of the report: Allison Sandiford
Completion Date: 1st December 2021

Contents

The Review Process

1. This summary outlines the process undertaken by East Sussex Safer Communities Partnership domestic homicide review panel in reviewing the homicide of Deborah who was a resident in their area.

2. Pseudonyms have been in used in this review for the victim, perpetrator, and other parties to protect their identities and those of their family members.

3. Deborah was aged 58 years when she was found deceased at her home address with multiple stab wounds to her face and upper body. Paul, her husband was found guilty of her murder. He was 62 years of age at the time of the fatal incident. Both Deborah and Paul identify as White British.

4. Deborah and Paul have two children, Harry, and Isobel. The children have complex needs and require extensive support.

5. Deborah died due to a stab wound to her neck. Criminal proceedings were completed in February 2021 and Paul was found guilty of murder and sentenced to life imprisonment with a minimum term of 25 years.

6. The DHR process began with a meeting of the East Sussex Multi-Agency DHR Oversight Group making a recommendation to the Chair of the Safer Communities Board, who approved the recommendation that the DHR threshold met and to commence a domestic homicide review. All key agencies, that potentially had contact with Deborah and Paul prior to the point of death, were contacted and asked to confirm whether they had involvement with them and for initial information to be provided to inform the initial chronology.

7. Eight of the eleven agencies contacted confirmed contact with Deborah or Paul or the children and were asked to secure their files.

Contributors to the Review

8. The following agencies contributed to the review.

Agency	Agency Report	Learning Event Attendance	Recall Day Attendance
Change Grow Live	✓	✓	✓
Sussex Partnership NHS Foundation Trust	✓	✓	✓
Sussex Police	✓	✓	✓
Children's Continuing Care East Sussex	✓	✓	✓
Adult Social Care and Health	✓	✓	✓
East Sussex Health Care Trust	✓	✓	✓
Sussex Clinical Commissioning Groups	✓	✓	✓
Children's Disability Service	✓	✓	✓

The following agencies and organisations also contributed to the review by returning a detailed summary of involvement request and chronology and information relating to all and any contact with the victim, perpetrator and any relevant information related to involvement in supporting the children:

- Chailey Heritage Foundation
- Turning Point
- Demelza Hospice Care

9. Individual Agency Management Reports have been provided by independent review officers within the single agencies.

The Review Panel Members

- **Donna Ohdedar -** Independent Chair, Review Consulting. Attended and Chaired panel meetings, the Learning Event, and the Recall Event.
- **Allison Sandiford -** Independent Author, Review Consulting. Attended all panel meetings, the Learning Event, and the Recall Event.
- **Natasha Gamble –** Strategy and Partnership Officer, Domestic Abuse, Sexual Violence and Abuse and Violence Against Women and Girls Joint Unit, Brighton and Hove and East Sussex.
- **Kaveri Sharma –** Joint Strategic Commissioner for Domestic and Sexual Abuse and Violence Against Women and Girls, Domestic Abuse, Sexual Violence and Abuse and Violence Against Women and Girls Joint Unit, Brighton and Hove and East Sussex.
- **Jane Wooderson –** Detective Sergeant, Safeguarding Reviews, Strategic Safeguarding Team, Sussex Police.
- **Douglas Sinclair –** Head of Safeguards and Quality Assurance, Children's Services, East Sussex County Council.
- **Debbie King –** Service Manager, Change Grow Live, East Sussex Domestic Abuse Service.
- **Fiona Crimmins –** Designated Nurse Adult Safeguarding, Sussex Clinical Commissioning Groups.
- **Sergio López-Gutiérrez -** Designated Nuse Children's Safeguarding, Sussex Clinical Commissioning Groups.
- **Gail Gowland –** Head of Safeguarding (adults and children), East Sussex Health Care Trust.

- **George Kouridis –** Head of Service Adult Safeguarding and Quality, Adult Social Care and Health Department, East Sussex County Council.
- **Bryan Lynch –** Director of Social Work, Sussex Partnership NHS Foundation Trust.

Chair and Author of the Overview Report

10. The review has been chaired by Donna Ohdedar. Donna has 16 years public-sector experience, including her last role as Head of Law for a leading metropolitan authority. Now a safeguarding adviser and trainer, Donna is involved in serious case reviews in both children's and adults' safeguarding, domestic homicide reviews and SILP.

11. The report has been authored by Allison Sandiford. Allison has legal training and has worked for Greater Manchester Police, specialising in Safeguarding. Allison has conducted children's and adults safeguarding reviews and domestic homicide reviews, both independently and with SILP.

12. Both are independent with no links to the East Sussex Safer Communities Partnership or any of its partner agencies.

Terms of Reference for the Review

13. The terms of reference[1] were agreed and to ensure a thorough multi-agency review of the circumstances in which Deborah died, the review was asked to consider the following:

1. What was known about Paul's mental health and his aggression and anger?
2. Were agencies aware of Paul having any drug or alcohol misuse issues?
3. What risk factors had agencies identified during previous involvement with the family dating from 2017/2018 and how did this affect their responses to concerns within the scoping period?
4. Could communication and information sharing have been improved during the scoping period.
5. What was understood by services about Deborah's recognition of risk of domestic abuse?
6. Please comment on agencies' identification and assessment of risk.
7. Were there missed opportunities to exercise professional curiosity and were opportunities missed to identify risk at any stage?
8. What did professionals understand about the lived experience of the family and how did agencies work with one another to manage the complexity of their situation?
9. Were there any barriers to Deborah accessing services?
10. Identify examples of strong practice, both single and multi-agency.

Summary Chronology

Brief Background

14. Deborah and Paul married in 1995. Within a couple of years, they had decided to foster children and proceeded to adopt Harry in 2007 and Isobel in 2012. The children have complex needs and require extensive support.

[1] Appendix 1: Project Plan

15. Paul was known to suffer with anxiety and depression. He had misused alcohol historically and Deborah had disclosed two domestic incidents that had occurred whilst he was under the influence of alcohol at this time.

16. In February 2018, following Section 47 enquiries relating to parental capacity, Paul's mental health and Paul's alcohol consumption, the children were made subject to Child Protection Plans under the category of emotional abuse. The plans were discharged In May 2018.

Assessment and Response to Paul's decline in Mental health

17. In March 2020 Paul's mental health again started to deteriorate and he attended the hospital with Deborah. Prior to discharge, Paul was assessed by the Mental Health Liaison Team who prescribed medication to aid his sleep and gave advice.

18. The following day, Paul re-presented at the hospital disclosing suicidal thoughts. He requested inpatient admission, but a bed was not available for another 48 hours. In the interim staff discharged him and scheduled a home visit from the Crisis Resolution Home Treatment Team (CRHT) for the following day.

19. The following morning Deborah found Paul sat holding a knife to his throat. Upon attending the hospital, Paul disclosed that he had drank alcohol a couple of weeks earlier. Paul remained in the hospital until a bed was found for him on a Psychiatric Unit.

20. At this time, because Deborah and Paul were known to be caring for children with disabilities, consideration was given by staff in A&E to raising a safeguarding concern, but for unknown reasons one was deemed to not be necessary. Upon reflection staff have agreed that not raising a safeguarding concern to children's services was an oversight.

Lesson 1

Staff in A&E must raise safeguarding concerns to Children's Social Care in accordance with their safeguarding policy and procedure, when deteriorating mental health and alcohol misuse is disclosed.

On-going Support and the Response to the Overdose

21. Paul stayed on the Psychiatric Unit for 12 days. Following discharge to his home address he received regular home visits from CRHT and completed three sessions of cognitive behavioural therapy for insomnia. Due to Covid restrictions, these sessions were delivered by a psychologist over the telephone.

22. On 10th April 2020 Deborah reported to CRHT that Paul had taken an overdose of Oramorph. He was taken to hospital and informally admitted to the Psychiatric Unit as the risks to himself were not being mitigated by community support.

The Management of Paul's Discharge following Deborah's Decision to Separate

23. Whilst Paul was an inpatient, Deborah voiced her decision to separate from Paul stating that she would not have him back in the house with the children due to his increasingly risky and deceptive behaviour.

24. Soon after, during a 1:1 session with a nurse on the ward, Paul spoke of having lots of jealousy towards his wife due to her having a good support network, the money, the house, and the children. Within days, he told a social worker that when he thought about the marriage breakdown, he had a desire to hurt either himself or Deborah and that he couldn't bear to see her with anyone else.

25. With parents' agreement the children were transported to care services on a short term basis whilst Children's Services commenced Section 47 enquiries. A few weeks later in May 2020, an initial child protection conference convened to consider Paul's deteriorating mental health difficulties and Deborah's ability to manage the children's needs as sole carer. Both children were made subject to plans under the category of emotional abuse.

26. Paul's comments were assessed by a Psychologist and Paul was asked what he would do if he experienced intrusive thoughts of harming himself or others after discharge. Paul replied that he would contact professionals and would not harm his wife. It was decided that a safeguarding concern did not need to be raised.

27. Following Paul's discharge on the 6th of May 2020 from the unit to accommodation separate from Deborah and the children, CRHT nurses and support workers had daily telephone contact with him. He described feeling isolated in his new home but said that interactions with Deborah had proved amicable and that he had attended the family home on several occasions with Deborah's agreement to collect possessions.

28. During a telephone call with his lead practitioner on the 23rd of June 2020, Paul described his mood as good and spoke of job interviews. Fortnightly telephone calls were agreed until the next outpatient appointment with the Consultant Psychiatrist when discharge would be considered if his mood had remained stable.

29. Deborah was found deceased in the family home prior to this appointment.

Key Issues arising from the Review – Analysis by Theme

30. Following multi-agency discussions of the Key Episodes and Terms of Reference, the following themes have been identified for practice and organisational learning:

The Effect of the National Lockdown

31. Paul's experience of hospitals/health centres at a time when staff were frenetically preparing for the pandemic does not seem to have been adversely affected. His transition into the Psychiatric Unit was timely and appropriate and his discharge back into the community has not been established by professionals as premature.

32. The major adaption to working practice that Paul had to navigate was post both discharges from the units when face-face contact with the CRHT was replaced by telephone contact. Paul engaged with these but has said that it was easier to say he was 'okay' over the telephone. There is nothing to evidence that these remote contacts had any adverse effect with regards to the frequency of contact and substance of the psychological work undertaken him.

33. However, it must be asked whether professionals' lack of face-to-face contact impacted their ability to fully understand the family's lived experience. It is recognised that this is less likely in the case of Deborah as she was undergoing assessments regarding the children and upon Isobel returning home, continued to be supported by a carer who attended the home address frequently. But Paul was now living independently in a new address whilst simultaneously recovering from a decline to his mental health, and it would have been challenging for practitioners to understand the impact upon him of these changes without face-to-face contact in the home at different times of the day.

34. The national lockdown affected Deborah in different ways. She spoke to her sister about feeling isolated, and her contact with Change, Grow, Live in April 2020 was affected as staff consequently working from home lost the in-office immediate oversight of line managers and Independent Domestic Violence Advisers. This resulted in a full case file not being opened and a consequent loss of full case management and oversight.

Use of Language in Recording and Assessment

35. Paul was described as 'aggressive' and to have shown 'aggression' in some of the chronology and reports submitted to the DHR. This was because it was a word that had been used to describe Paul within some practitioner's notes.

36. Information provided to the review which is referring to Paul's behaviour during a youth group session, records that Paul was *vocally aggressive;* had *aggressive body language and* displayed *irrational behaviour.* The record makes it clear that Paul's aggression was borne out of disagreements with staff regarding Harry's care needs, but it would have benefitted from more description about the circumstances and whether this presentation was unusual for Paul.

37. In contrast, when Change Grow Live recorded that Deborah had disclosed some historic aggression by Paul, the Change Grow Live worker asked further questions. This resulted in fuller description.

38. This use of extra description distinguishes between fact and opinion within the case notes. Although inclusion of opinion is not essentially a problem - it should be substantiated by fact as deeper understanding of case notes is crucial. In particular because what is recorded in files can have a huge impact on what next steps are taken and what support package is put in place.

Lesson 2

All practitioners should understand the importance of using descriptive language in case notes to help a reader distinguish between fact and opinion.

Consideration of Paul's use of Alcohol in Assessments.

39. When Paul first presented to the Mental Health Liaison Team in A&E, he denied alcohol being a current issue. He said that he hadn't drank for two years and was attending AA meetings. Two days later, he backtracked and disclosed that he had drank the previous month and was no longer attending AA.

40. Although Paul was asked about his alcohol consumption in the mental health hospital, there is no evidence of any further questions asking Paul why he had stopped attending AA, or what might have triggered him to drink again. Similarly, there is no evidence of any conversation with Deborah being had in confidence to provide her an opportunity to disclose more information or discuss any suspicions of Paul using alcohol on other occasions.

41. The review has recognised that Paul did not disclose any level of alcohol consumption that would put his health at an increased risk and therefore require further exploration, but his drinking is concerning when considering any possible risk to Deborah and the children. This is because during a family assessment in 2014, Deborah had disclosed two incidents of aggression by Paul towards her that had occurred whilst he was consuming alcohol - suggesting that Paul may be prone to being angry when drinking.

Interaction between Professionals and Deborah

42. There were many opportunities to ask Deborah about domestic abuse without Paul being present. Some opportunities were exercised well by professionals, but others, such as when Deborah attended routine medical appointments, went unnoticed.

43. Deborah had on-going physical health problems for which she attended annual reviews. During her health reviews, Deborah should always have been asked depression screening questions and, in addition clinicians should have been aware of any 'key indicators for domestic abuse'. Although no concerns are recorded on Deborah's notes, there is no evidence of questions being asked.

Lesson 3
Clinicians must remember to ask procedural questions about depression/domestic abuse when seeing patients with non-specific symptoms or symptoms suggestive of domestic abuse and record the reply.

44. During a joint visit between the police and the children's disability service to assess whether the children might be at risk of any significant harm, it is evident that Deborah was offered the opportunity to disclose information about any domestic abuse. She spoke at length about her concerns for her husband and spoke openly of events leading up to the overdose incident. But she made it clear that she was concerned for Paul and wanted him to get the treatment that he needed. She said that she was not making any allegations against him about his treatment of her or the children. Deborah did not make any disclosure or indicate in any way that she had been the victim of any form of domestic abuse.

45. However, consideration must be had that not everyone recognises domestic abuse, particularly if it is not physically violent. Domestic abuse is complicated and even some people who have or are going though it are unclear as to what constitutes abusive behaviour.

Lesson 4
Professionals must remember that not everyone understands what constitutes domestic abuse behaviour.

46. Deborah was able to present herself in a professional and confident manner. This may have made it harder for some professionals to ask probing questions about her relationship in order to assess her situation. Indeed, it is recognised that assessing anyone's personal experiences within

their private relationships can be uncomfortable but both probing and clarifying questions needed to be asked in an attempt to identify Deborah's understanding of abuse.

47. *'Learning to ask questions that open up possibilities is an art form that takes practice'*[2] and practitioners at the Learning Events discussed how personal questions have to be placed correctly into a conversation. Asking them too early can cause a person to feel defensive and shut down.

Lesson 5

Practitioners must be aware of the importance of probing questions being asked in a sensitive, timely manner and they must be supported to acquire such skill. Such questions should not be omitted in any circumstances, including when the person/client is one with a professional background and/or a confident manner.

Assessing Heightened Risk

48. During a 1:1 session with a nurse on the ward soon after Deborah had communicated her decision to separate, Paul spoke of jealousy towards his wife. Within days, he told a social worker that when he thought about the marriage breakdown, he had a desire to hurt either himself or Deborah.

49. In 2019 a criminology expert Dr Jane Monckton Smith established a homicide timeline which could be tracked by professionals to help them to prevent deaths. The timeline follows an eight-stage pattern.

50. The eight steps Dr Jane Monckton discovered in almost all of the 372 killings she studied were:

- A pre-relationship history of stalking or abuse by the perpetrator
- The romance developing quickly into a serious relationship.
- The relationship becoming dominated by coercive control.
- A trigger to threaten the perpetrator's control - for example, the relationship ends, or the perpetrator gets into financial difficulty.
- Escalation - an increase in the intensity or frequency of the partner's control tactics, such as by stalking or threatening suicide
- The perpetrator has a change in thinking - choosing to move on, either through revenge or by homicide
- Planning - the perpetrator might buy weapons or seek opportunities to get the victim alone.
- Homicide - the perpetrator kills his or her partner, and possibly hurts others such as the victim's children.

51. Had a professional considered Paul against the pattern at this time, it would have been recognised that the relationship fit the early stages of the model and that his current threats of suicide and thoughts of revenge and/or homicide indicated that he had reached stage 5 and 6.

52. Following assessment of Paul, a decision was made not to raise a safeguarding concern. This meant that the information was not shared with other agencies and other professionals lost the opportunity to assess their support in light of Paul's comments.

[2] Graybeal C (2001) Strengths-based social work assessment: Transforming the dominant paradigm' Families in Society, Volume 82, Number 3, pp233-42, (p241)

53. The comments weren't shared with Deborah either as Paul did not consent for information to be shared with her or any other family members. Given that professionals are aware that the risk of domestic abuse is heightened at the point of separation, deeper consideration could have been had to sharing Paul's information with Deborah. At the least, in light of his comments, advice could have been given to Deborah at the point of discharge about the risk of domestic violence at separation.

54. This was also another opportunity to utilise the aforementioned Dr Monckton homicide timeline. Sharing it with Deborah would have given her a tool to help her to recognise and articulate her situation. Recognition of her own relationship[3] in the early stages of the timeline may have raised her guard and understanding.

Lesson 6
The Dr Monckton Smith homicide timeline supports both victims and professionals to recognise risks of domestic abuse.

Consideration of the Whole Family

55. The review has highlighted opportunities for professionals to apply the Whole Family approach to this case – an approach that encourages services to consider the family as a whole, as opposed to responding to each problem, or person in isolation.

56. When Paul informed professionals at the mental health unit of his desire to hurt either himself or Deborah and of the struggles he was having coming to terms with the separation, the experienced consultant in charge of Paul's care worked through the threats with Paul and did not deem risk.

57. However, the question, *would* Paul *have further disclosed any thoughts of harming Deborah,* must be asked. A study: *Healthcare experiences of perpetrators of domestic violence and abuse*[4], has identified factors that act as barriers to a perpetrator disclosing domestic violence in a healthcare setting, as including a fear of other services being informed and involved. Paul understood the social care system well and would have known the consequences of children's social care learning of his thoughts.

58. Although the practicalities of raising a safeguarding concern every time a patient in a therapeutic environment voices a want to hurt someone is recognised, the non-sharing of Paul's spoken desire to hurt Deborah, whether deemed a risk or not by Sussex Partnership NHS Foundation Trust, prevented other safeguarding agencies from having the opportunity to complete a DASH and/or consider any risk posed by Paul.

59. This is dangerous as it is those who work with the family within the community who have the broadest picture of the situation. Significantly, in this case, the professionals working with Deborah and Paul had a good understanding of their stresses as carers for the children and would have been able to take this into consideration when risk assessing.

[3] Paul had been accused of abuse by a previous partner and Deborah and Paul married the year after their relationship started.
[4] Healthcare experiences of perpetrators of domestic violence and abuse: a systematic review and meta-synthesis | BMJ Open

60. The focus of risk assessment may differ between agencies; Sussex Partnership NHS Foundation Trust knowing that Paul and Deborah were to separate may have lessened their focus upon safeguarding the family (as they perceived Paul moving out of the family home as a protective factor). Their focus may have been more about the risk that Paul posed to himself.

61. Sussex Partnership NHS Foundation Trust shared Paul's admission with his GP and on the 15th of April 2020, the surgery received a notification letter. A rapid response nurse had documented within it that there had been concerns about the safety of Paul's wife and children when Paul had been most unwell but that this was now reduced, and Children Social Care were aware. There was no further explanation regarding the recent concerns to the family, and the letter was filed.

62. In line with the Whole Family approach, good practice upon receiving this letter would have been to contact Deborah to check whether she or the family needed any additional help. This should have been regardless of previous knowledge of historical concerns.

Lesson 7
The GP surgery must assess risk management, and apply the Whole Family approach, to all letters received from outside agencies.

63. The omission of a multi-agency discharge meeting from the Psychiatric Unit resulted in the agencies working with the family outside of the Sussex Partnership NHS Foundation Trust having less knowledge of the situation. This resulted in a less accurate assessment of risk and a lack of opportunity to consider how Paul's discharge would affect everyone around him. A multi-agency discharge planning meeting would have provided a last chance to share information and consider the Whole Family before Paul returned to the community.

Lesson 8
Opportunities for multi-agency working could be enhanced through more effective information sharing when a patient is discharged by means of a discharge planning meeting.

Communication between Services and Significant Others

64. Communications between services within the Sussex Partnership NHS Foundation Trust and Deborah could have been better during the timescale of the review. They had diminished because it was very soon after Paul's admission onto the unit that Deborah voiced her decision to separate, and without Paul's consent mental health professionals did not have the authority to share any of Paul's information.

65. Nevertheless, including Deborah in Paul's care planning could have proved invaluable to Paul's recovery, Deborah's safety, the children's safety, and everyone's emotional welfare. Even in the event of separation it would have been worth having a conversation with Paul to encourage him to give consent to continue to share his information. The benefits of including another in his care plan could have been explained and in the event of him still refusing to share with Deborah, he could have been encouraged to choose another relative or friend to support him.

66. There would have been a benefit to including Deborah, or a significant other, in discussions about Paul's background, and the changes in his behaviours as his mental health had deteriorated,

as their input would have improved professionals understanding of Paul. It would also unquestionably have reduced the reliance that professionals had on Paul's self-reporting. Which had already on occasions, been proven contradictory.

Support for Deborah following Separation.

67. In May 2020 the children were made subject to a protection plan under the category of emotional abuse. Although this was due to the concerns around the deterioration of Paul's mental health, Deborah expressed to Children Disability Service that she felt that *she* was being punished for his behaviours. Deborah reiterated her uneasiness towards the plan and social care when she confided in a Forward Facing[5] worker and said that *she wasn't scared of* Paul but was *more scared of social services.* Deborah spoke of not being able to say what she wanted because she feared social care might take her children away from her.

68. Children's Social Care were initially involved, not because Deborah or Paul had caused significant harm to the children, but because they were parenting in circumstances of adversity given the children's complex needs. When Paul's mental health started to decline, Deborah reached out to CDS and kept them updated of the situation. Following Paul's admission to the unit, Deborah found herself in the position of being subject to child protection investigations, which resulted in her children being made subject to a child protection plan. Potentially, from Deborah's point of view, she had asked for support and was now being punished. Professionals may argue that the plan was initiated to support the children and Deborah, but as evidenced through her conversation with the Forward Facing worker, Deborah clearly viewed it as an ongoing assessment of her ability to meet the children's needs and to keep them safe. She could therefore have potentially worried about any affect disclosures of domestic abuse would have had on social care's view of how she could care for her children and keep them safe.

69. Deborah's opinion of the plan, regardless of whether it was right or wrong, undoubtedly served as a possible barrier to her being open about any new concerns she may have had regarding the actions of Paul. As such, voluntary disclosure of any emerging concerns was less probable.

Lesson 9

There may be a barrier preventing victims of domestic abuse accessing support where they are concerned for the implications such disclosure would have on their perceived ability to meet their children's needs.

70. The first agency that considered support for Deborah in her own right, following the marriage separation was Change Grow Live. The Children's Disability Service and the police had suggested that she contact them for advice, and it was thereafter deemed to be a positive sign when Deborah followed this advice and contacted them. But it could have been as a possible indicator of the true extent of difficulties that Deborah was facing at the time.

Conclusions

71. Deborah was the tragic victim of a domestic homicide perpetrated by her husband after they had separated. Neither agencies or family/friends were aware of Deborah being subject to any ongoing domestic abuse although some professionals were aware of two historic incidents

[5] A charity supporting children and young people with long term illnesses or life threatening conditions.

between Paul and Deborah. These had occurred when Paul was known to be misusing alcohol but following Paul seeking support and addressing his alcohol problem, no further incidents were reported.

72. Deborah did not voice any concerns regarding Paul's behaviours to the Children's Disability Services, the police or Change, Grow Live. However, we have heard from family and friends that Deborah had expressed that she was unable to say what she wanted to because she feared social care might take her children away. She did not elaborate on this and did not disclose any domestic abuse to anyone within her personal support network – familial or friend.

73. Information held by agencies was never sufficiently high risk enough to identify Deborah as a high risk victim of domestic abuse but there is a disparity between what different agencies knew as only the mental health unit knew of the comments made by Paul regarding wanting to hurt Deborah.

74. The homicide occurred during the covid pandemic. Whilst Paul had spoken of the effect that the pandemic had on him, and Deborah had talked of feeling isolated, there is nothing covid related that has led to learning for this review.

75. Following discharge from the mental health unit and upon the approach to Deborah's tragic murder, there was no visible decline to Paul's mental health. If Deborah did have any concerns, she did not disclose them, although she does appear to have been worried about something because she sought advice about changing the locks and considered an Occupational Order.

Lessons to be Learned.

76. Lesson 1
Staff in A&E must raise safeguarding concerns to Children's Social Care in accordance with their safeguarding policy and procedure, when deteriorating mental health and alcohol misuse is disclosed.

77. Lesson 2
All practitioners should understand the importance of using descriptive language in case notes to help a reader distinguish between fact and opinion.

78. Lesson 3
Clinicians must remember to ask procedural questions about depression/domestic abuse when seeing patients with non-specific symptoms or symptoms suggestive of domestic abuse and record the reply.

79. Lesson 4
Professionals must remember that not everyone understands what constitutes domestic abuse behaviour.

80. Lesson 5
Practitioners must be aware of the importance of probing questions being asked in a sensitive, timely manner and they must be supported to acquire such skill. Such questions should not be omitted in any circumstances, including when the person/client is one with a professional background and/or a confident manner.

81. Lesson 6
The Dr Monckton Smith homicide timeline supports both victims and professionals to recognise risks of domestic abuse.

82. Lesson 7
The GP surgery must assess risk management, and apply the Whole Family approach, to all letters received from outside agencies.

83. Lesson 8
Opportunities for multi-agency working could be enhanced through more effective information sharing when a patient is discharged by means of a discharge planning meeting.

84. Lesson 9
There may be a barrier preventing victims of domestic abuse accessing support where they are concerned for the implications such disclosure would have on their perceived ability to meet their children's needs.

Recommendations from the Review

85. The review would like to thank agencies for their single agency learning outlined within their reports[6].

86. The following ***single-agency recommendation*** is made to SPFT:

- SPFT to address how practitioners respond to threats of risk of harm to family members made by an inpatient of mental health service and consider whether a policy needs producing or whether an existing policy needs amending.

87. The review would ask that ESSCP monitor action plans and that outcomes are impact assessed within the organisations.

88. The following ***multi-agency recommendations*** are made to ESSPC:

Recommendation 1

ESSCP should produce guidance regarding best practice 'use of language' in recording and assessment and ensure that all partner agencies incorporate it into their staff training.

Recommendation 2

ESSCP to ensure that health practitioners are aware of the NICE quality standard regarding clinical indicators of domestic abuse.

Recommendation 3

ESSCP to raise the public awareness of domestic abuse.

Recommendation 4

[6] Appendix 2: Single Agency Recommendations

ESSCP to raise awareness across all partner agencies of Dr Jane Monckton Smith's eight-stage domestic homicide pattern model and ensure that they are aware of the benefits of incorporating it into practice.

Recommendation 5

ESSCP to review existing training programmes and ensure that practitioners embed a 'Whole Family' approach into their practice, that includes:

- How practitioners respond to threats of risk of harm to family members, and
- Identification of carers' stresses and any resulting risk to others

Appendix 1: Terms of Reference and Project Plan

EAST SUSSEX

SAFER COMMUNITIES

PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

TERMS OF REFERENCE & PROJECT PLAN

SUBJECT: DEBORAH

DATE OF BIRTH: REMOVED

DATE OF DEATH: JULY 2020

VERSION 2: 18.12.2020

1. *Introduction:*

1.1 This Domestic Homicide Review is commissioned on behalf of East Sussex Safer Communities Partnership in response to the death of Deborah. Deborah was found deceased at the family home in East Sussex. She had suffered multiple stab wounds. Paul has been charged with her murder and is currently remanded in custody.

1.2 Deborah and Paul had been married for 25 years when Deborah made the decision in April 2020 that their marriage was over, due Paul's increasingly risky and deceptive behaviour. Paul had a history of mental health problems and had attempted to harm himself twice in March and April 2020. He also had a history of misusing alcohol.

1.3 Upon his discharge from hospital in May 2020, Paul moved into a different address. Deborah and Paul have 2 adopted children, both with special needs. The youngest child remained living with Deborah whilst the eldest resided away from home in a residential placement. The youngest was present in the address when *Deborah* was found deceased.

1.3 The East Sussex Safer Communities Partnership is keen to establish how agencies may have worked individually and together to better safeguard Deborah. It wants to explore whether there were missed opportunities to have engaged with the family. The review will explore whether the risk to Deborah was recognised and whether there were any barriers to Deborah accessing services. If so, what can be done to raise awareness of domestic abuse in such circumstances and of the services available to victims of domestic violence and abuse.

2. Legal Framework:

2.1 A Domestic Homicide Review (DHR) must be undertaken when the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-

(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.

2.2 The purpose of the DHR is to:

a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

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

c) apply these lessons to service responses including changes to policies and procedures as appropriate; and

d) prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children by developing a coordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

e) contribute to a better understanding of the nature of domestic violence and abuse; and

f) highlight good practice

3. Methodology:

3.1 This Domestic Homicide Review will be conducted using the Significant Incident Learning Process (SILP) methodology, which reflects on multi-agency work systemically and aims to answer the question why things happened. Importantly it recognises good practice and strengths that can be built on, as well as things that need to be done differently to encourage improvements. The SILP learning model engages frontline practitioners and their managers in the review of the case, focusing on why those involved acted in a certain way at that time. It is a collaborative and analytical process which combines written Agency Reports with Learning Events.

3.2 This model is based on the expectation that Case Reviews are conducted in a way that recognises the complex circumstances in which professionals work together and seeks to understand practice from the viewpoint of the individuals and organisations involved at the time, rather than using hindsight.

3.3 The SILP model of review adheres to the principles of;

- Proportionality
- Learning from good practice
- Active engagement of practitioners
- Engagement with families
- Systems methodology

4. Scope of Case Review:

4.1 Subject Deborah: Date of Birth: Removed

4.2 Scoping period: from 06.03.2020 [the time that Deborah reported a significant decline in Paul's mental health] to 07.2020 [the date that Deborah was found dead]

4.3 In addition agencies are asked to provide a brief background of any significant events and safeguarding issues prior to the scoping period that agencies consider would add value and learning to the review.

5. Agency Reports:

5.1 Agency Reports will be requested from:

- Police
- Children's Services - Children Disability Service/ Children and Young Peoples Continuing Care
- Chailey Heritage Foundation
- Change Grow Live
- GP X2
- Adults Social Care
- Sussex Partnership NHS - Assessment and Treatment Service/Health in Mind/Mental Health Liaison Service
- Demelza Hospice Care for Children
- Crisis Resolution Home Treatment Team
- East Sussex Healthcare Trust
- Turning Point - The Sanctuary

5.2 Agencies are requested to use the attached Report Template.

6. Areas for consideration:

6.1 What was known about Paul's mental health and his aggression and anger?

6.2 Were agencies aware of Paul having any drug or alcohol misuse issues?

6.3 What risk factors had agencies identified during previous involvement with the family dating from 2017/2018 and how did this affect their responses to concerns within the scoping period?

6.4 Could communication and information sharing have been improved during the scoping period.

6.5 What was understood by services about Deborah's recognition of risk of domestic abuse?

6.6 Please comment on agencies' identification and assessment of risk.

6.7 Were there missed opportunities to exercise professional curiosity and were opportunities missed to identify risk at any stage?

6.8 What did professionals understand about the lived experience of the family and how did agencies work with one another to manage the complexity of their situation?

6.9 Were there any barriers, to Deborah accessing services?

6.10 Identify examples of strong practice, both single and multi-agency.

7. Engagement with the family

7.1 A key element of SILP is engagement with family members, in order that their views can be sought and integrated into the Review and the learning. The independent lead reviewer will follow up with the family by contacting Deborah's sister who will be consulted on the terms of reference for the review (subject to consultation re: criminal process).

7.2 Further contact will be made to invite participation in the form of a home visit, interview, correspondence, or telephone conversation prior to the Learning Event. Contributions will be woven into the text of the Overview Report, and she will be given feedback at the end of the process.

8. Timetable for Domestic Homicide Review:

Stage	**Date**
Scoping Meeting	4th December 2020
Letters to Agencies	18th December 2020
Agency Report Authors' Briefing	15th January 2021
Engagement with family	Begin once authorised
Agency Reports submitted to ESSCP	14th April 2021
Agency Reports quality assured by chair	14th- 20th March 20221
Agency Reports distributed	21st April 2021
Learning Event	29th April 2021

Stage	Date
First draft of Overview Report to ESSCP	2nd June 2021
Recall Event	9th June 2021
Second draft of Overview Report to ESSCP	16th June 2021
Presentation to ESSCP Sub Group	July 2021

Version 2: 18.12.2020

Appendix 2: Single Agency Recommendations

1. **CGL**
   - Contact to be made with statutory services undertaking assessments for clients who self-refer.
   - A full case file to be opened where there are no safeguarding concerns disclosed.

2. **SPFT**
   - Where a patient has a history of risk-taking behaviour, ensure that this is fully assessed, documented and handed over when a new team is engaged in care.
   - All allegations of domestic violence to be fully risk assessed and reported to the appropriate agencies.
   - Impact of Covid19 to be identified for all patients and risks documented and managed accordingly.
   - Ensure compliance with safeguarding training and a Think Family approach is employed and documented.

3. **CCC**
   - Discussion to be had with agency and care staff to address the inability to recruit and maintain nurses and carers in a home package.
   - Monthly reports from the care agency to continuing care to include a section to feedback any safeguarding concerns.

4. **Primary Care**
   - Review training provided for surgery admin staff.
   - Encourage use of codes to flag people at risk of domestic abuse, carers, child protection plan or children social care involvement.
   - Review of workflow policy.
   - Review practice new patient policy to ensure vulnerable patients are prioritised

5. **ESHC**
   - Cross-referencing of safeguarding notes between adult records and children records, where there are risks that affect care.
   - Ensure that Staff have an understanding of the correlation between Domestic Abuse and physical health presentations.
   - Where staff identify a potential risk that may warrant a referral for safeguarding documentation should clearly reflect whether this has occurred.

6. **CDS**

- Practitioners to develop a greater awareness of the impact of mental health difficulties, particularly combined with domestic abuse, and alcohol misuse upon risk and to demonstrate greater professional curiosity in escalating situations.
- Practitioners within the Transitions Service to increase their confidence and awareness of domestic abuse even when the lead social worker in their case for Child Protection is a CDS practitioner.
- Where cases involve parent carers who hold positions of authority and present as competent and confident, practitioners should be mindful not to accept information at face value, especially when there have been indicators of concern in the past.
- Where children have high levels of formal funded support, practitioners and managers should ensure that they don't become pre-occupied with the child's day to day care arrangements and lose focus on underlying risk factors and what else might be happening in the family.