DOMESTIC HOMICIDE REVIEW:
Executive Summary

Hampshire Borough of Havant

Case of Barbara C

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Executive Summary

This summary outlines the process undertaken by Havant Community Safety Partnership Domestic Homicide Review Panel in reviewing the death of Barbara C.

1. Summary of incident

1.1. On the 23 November 2013 Barbara C (aged 81) was found dead at her home. Owen C her husband (aged 80) has since been found guilty of manslaughter.

Table to show family composition:

Name	Relationship	Ethnic origin
Barbara C	Victim	White British
Owen C	Perpetrator -husband	White British
Charles C	Son	White British
Danielle G	Granddaughter	White British

2. The review process

2.1. The full terms of reference are included in Appendix 1. The essence of this review is to establish how well the agencies worked both independently and together and to examine what lessons can be learnt for the future.

2.2. The process began with an initial meeting on 24 February 2014 of all agencies that potentially had contact with Barbara C prior to her death.

2.3. The approach adopted was to seek chronologies and Individual Management Reviews (IMRs) for all organisations and agencies that had contact with Barbara C or Owen C. It was also considered helpful to involve those agencies that could have had a bearing on the circumstances of this case, even if they had not been previously aware of the individuals involved. This information was shared at panel meetings and an agreed set of recommendations made.

3. Agencies participating in this case review

3.1. The following agencies were involved in this case review:

a. South Eastern Hampshire Clinical Commissioning Group and Bosmere Practice GP Surgery, Havant
b. Southern Domestic Abuse Service

c. Adult Services
d. Portsmouth Hospital NHS Trust
e. Havant Borough Council
f. Hampshire Constabulary
g. Hampshire Probation Trust
h. Victim Support
i. Somerset Care
j. Southern Health NHS Foundation Trust
k. Apetito (Meals on Wheels)
l. NHS Ambulance Service

4. IMRs

4.1. Agencies were asked to give chronological accounts of their contact with the victim prior to her death. Where there was no involvement or insignificant involvement, agencies advised accordingly. Each agency's report covers the following:

- A chronology of interaction with the victim and/or their family;
- what was done or agreed;
- whether internal procedures were followed; and
- conclusions and recommendations from the agency's point of view.

4.2. Some of the accounts have more significance than others. The extent to which the key areas have been covered and the format in which they have been presented varies between agencies.

4.3. A specialist older persons agency (such as Age Concern) was considered but not included as the Victim Support representative had expertise in working with older people, as did the representative from Adult Social Care. The family had not had any contact with any older people's organisations.

5. Contact with family

5.1. Several attempts were made to contact family members following the trial and appeal, however these were not successful. The Chair liaised with the Police Family Liaison Officer and agreement was reached that it was best to respect the family's wishes and not make further contact. Following completion of the report, contact was made with Danielle G and her sister. They reported this painful incident has completely split the family.

6. Key issues arising from the review

6.1. *Information Sharing*

There was evidence of good information sharing between agencies, especially health and Adult Social Care. Referrals were acted on swiftly. The GP practice is large and although record keeping was good the number of different doctors seen by the couple, especially over the last year, may have impeded an ability to notice a change in capacity and understanding, and for any one doctor to have a clear overview of the case. However, there is an ability for Multi-disciplinary meeting to be used to share information, and this was utilised in this case.

6.2. *Risk Assessment*

No specific allegations of domestic abuse were ever made although there was evidence that Barbara C could be aggressive at times. There was not any evidence of enquiry as to whether this was a regular factor in their relationship. From the information that was known, neither Owen C nor Barbara C would be deemed high risk according to the Safe Lives DASH. There is evidence that the stress of providing care increased significantly in late October/early November 2013, a care package to support Owen C in providing care was arranged swiftly, although at this stage there was no inquiry as to how this could affect their relationship.

6.3. *Understanding of the dynamics of DV and its impact*

Southern Health NHS Foundation Trust, Portsmouth Hospitals NHS Trust and Adult Social care have established and embedded training programmes about domestic abuse and safeguarding. Staff are aware of these and apply them although, at the time of the couples' interaction with these services, there was no indication that domestic abuse might be present. The GP surgery has a safeguarding policy but training is outsourced. There is not clear emphasis on domestic abuse as a safeguarding issue within that training and so it is possible that opportunities for safe inquiry (such as regular check-up appointments) may have been missed, although it is unlikely that Barbara C would have disclosed any abuse from Owen C as there

was no evidence of this prior to her death. Somerset Care staff has access to safeguarding training but this does not include aspects on domestic abuse. As an organisation that works in the homes of its clients there may have been opportunities to note indicators or make safe enquiry had staff been trained.

6.4. ***Agencies response***

There was no relevant prior contact with Hampshire Constabulary. The responses from Portsmouth Hospital NHS Trust were appropriate at that time. Adult Social care and Southern Health Foundation Trust shared information well and reacted swiftly to changes in circumstances. Somerset Care carried out their duties effectively and shared information well but, with increased training, they may have had the opportunity to notice indicators of abuse if they had been present. The GP practice provided caring and swift medical care to the couple but, again, with enhanced training may have noted risk indicators or found opportunity for safe enquiry about domestic abuse. A carer's assessment was offered.

6.5. ***Culture of curiosity***

Southern Health and Portsmouth Hospitals NHS Trust both appear to have embedded systems where safeguarding and specifically domestic abuse are appropriately considered and enquired about. Adult Social care also has clear safeguarding procedures and a carer's assessment was offered but declined. There was no recorded enquiry about Charles C and the effect of his presence in the home. Learning from other reviews has shown that it is always useful to be curious about any other members of the household. The lack of continuity due to the size of the GP practice means that increases in stress were hard to notice. Opportunities to make enquiries about domestic abuse such as at routine appointments were not taken but there was good communication between the multi-disciplinary team. Somerset Care also had opportunity to observe within the home, however as the staff had not received training about domestic abuse you would not expect them to make any enquiries.

6.6. ***Policies and processes***

A culture of curiosity is often enabled by embedded practice, policy and procedure. It is therefore not surprising that Portsmouth Hospital Trust, Adult Social Care and Southern Health all have established policy and training about domestic abuse. The GP practice and Somerset Care had Safeguarding Policies which staff were aware of, but these did not specifically link domestic abuse and safeguarding. All agencies were aware of "carer's" stress and this was identified and acted upon swiftly.

7. Conclusions and recommendations from the review

This tragic case could not have been predicted; there is no recorded evidence of domestic abuse in the relationship between Barbara C and Owen C prior to Barbara C's death. There is no evidence of Owen C ever being abusive or violent. Barbara C's condition (and the subsequent stress of caring for her and meeting her needs) deteriorated quite suddenly in November 2013 and although a care package was put in place swiftly it appears that the events of the morning of the 23 November 2013 could not have been predicted. Learning from this review may help to more swiftly identify cases of domestic abuse especially within a caring relationship in future, but there is not an identified course of action that could have prevented this death.

8. Recommendations from partner agencies

8.1. *Portsmouth Hospitals NHS Trust*

Several domestic abuse initiatives have already been introduced:

- Working group set up in 2014 to update guidance available for staff in relation to domestic abuse.
- Continue with domestic abuse training within the emergency department and roll-out to other staff across the Trust.
- Electronic staff record updated to allow capture of domestic abuse training data.

With regard to the specific areas identified within this review the following action is proposed:

- Share findings of investigation relating to discharge planning and referrals with Discharge Planning and relevant ward teams.

8.2. *Adult Social Care*

- It is recommended that staff always try to speak to the person being assessed without others present, even if only for a short time.

8.3. *Southern Health*

- Publication of Domestic Homicide Review report across all divisions of the Trust to raise the profile of the domestic violence and abuse within older adult relationships.
- Promotion of services available for carers and information and resources available.

8.4. *The GP Practice*

- Share specific areas identified with GP surgery, including GPs, nursing and administration staff and community care teams.
- Local education for GP practices on the identification of carer stress and support available.

8.5. ***Somerset Care***

- To work with local specialist to provide training about domestic abuse.

8.6. ***Hampshire Constabulary***

- There are no recommendations being made as a result of this review.

9. Recommendations from the Panel

9.1. See attached action plan below

Recommendation	**Report ref**	**Action to take**	**Lead**	**Key milestones achieved in enacting recommendation**	**Date**	**Date of completion and outcome**
Theme 1 – Information Sharing						
Adult Safeguarding Board to review information sharing practices and ensures their compliance with the need of the Care Act 2014, and to feed back to the Community Safety Partnership once complete.		Review of information sharing practices.	Jo Lappin HCC	N/A	May 2015	The Adult Safeguarding Board has an information sharing framework published in May 2015 reflecting Care Act requirements,which is contained on the HSAB website www.hampsiresab.org.uk The Hampshire Domestic Abuse Partnership website also offers support and guidance in this area http://www3.hants.gov.uk/healthandwellbeing/domesticabuse.htm
Theme 2 – Risk assessment						
CCG to explore all options in regard to better risk assessment in local GP surgeries e.g. IRIS Project		CCG to take overview of options to advise local GP surgeries of risk assessment process	South East CCG Pauline Dorn HCC Adult Safeguarding Jo Lappin	**CCG update June 2016** work ongoing CCG have been exploring options for developing domestic abuse awareness in primary care and are continuing to consider options. This has been discussed at our Joint Quality Assurance Committee and is on the agenda to be discussed in further detail at the next safeguarding focussed Quality meeting. The 15/16 Hampshire Domestic Abuse Strategy was shared with the Quality Assurance Committee members and any further updates from the	May 2016	The Hampshire Safeguarding Adults Board has just published the multi-agency risk management process available on the HSAB website www.hampshiresab.org.uk The Hampshire Domestic Abuse Partnership website also offers support and guidance in this area http://www3.hants.gov.uk/healthandwellbeing/domesticabuse.htm

				Hampshire Domestic Abuse Steering Group will also be shared.		
Theme 3 - Training						
The CSP to promote the Hampshire Domestic Abuse on-line training and consider DA to be a part of the LSAB Workforce Developing Group.		CSP to update website with relevant Domestic Abuse updates	Tim Pointer Safer Havant Partnership Jo Lappin HCC Adult Safeguarding Board	**CSP update June 2016** Safer Havant Partnership website has now been updated to include a "confidence" training booklet.	May 2016	The Hampshire Safeguarding Adults Board has published a training strategy for adult safeguarding including domestic abuse available on the HSAB. www.hamshiresab.org.uk www.saferhavant.co.uk The Hampshire Domestic Abuse Partnership website also offers support and guidance in this area http://www3.hants.gov.uk/healthandwellbeing/domesticabuse.htm
Theme 4 – Culture of curiosity						
The Chairs of the Safeguarding Adult's Board to discuss how good practice is shared and methods to develop this.		All to promote adults safeguarding board to promote website	All agencies	Ongoing	May 2016	The Safeguarding Adults Board in the Hampshire, Southampton IOW and Portsmouth area have a comprehensive learning and review framework which ensures that learning can be gained from serious cases and includes activities around the dissemination and support to put learning into practice. There is also a learning from experience website.
Theme 5 – Policies and processes						
All agencies to receive a copy of the report.		All agencies to note and disseminate as appropriate	Tim Pointer Safer Havant Partnership to circulate once evaluated by Home Office	June 2016	June 2016	Existing safeguarding policies and the care act cross-reference these issues.

2. Appendix 1

Domestic Homicide Review: Terms of Reference for Barbara C

This Domestic Homicide Review is being completed to consider agency involvement with Barbara C, and her husband, Owen C, following her death on 23 November 2013. The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

Purpose of the Domestic Homicide Review (DHR)

1. To place a statutory responsibility on organisations to share information. Information shared for the purpose of the DHR will remain confidential to the panel, until the panel agree what information should be shared in the final report when published.

2. To review the involvement of each individual agency, statutory and non-statutory, with Barbara C and Owen C during the relevant period of time: 1 January 2009 to 22 November 2013.

3. To summarise agency involvement prior to 1 January 2009.

4. To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to identify and respond to disclosures of domestic abuse.

5. To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result and as a consequence.

6. To improve inter-agency working and better safeguard adults experiencing domestic abuse and not to seek to apportion blame to individuals or agencies.

7. To commission a suitably experienced and independent person to:
    a. chair the Domestic Homicide Review Panel;
    b. co-ordinate the review process;
    c. quality assure the approach and challenge agencies where necessary; and
    d. produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established terms of reference.

8. To conduct the process as swiftly as possible, to comply with any disclosure requirements, and on completion, present the full report to the Safer Havant Partnership.

Panel Membership

1. The following agencies are to be involved:
    a. Hampshire Constabulary
    b. Community Safety, Havant Borough Council
    c. South Eastern Hampshire Clinical Commissioning Group
    d. Victim Support
    e. Southern Domestic Abuse Service
    f. Somerset Care
    g. Adult Services, Hampshire County Council
    h. Portsmouth Hospital NHS Trust

2. Where the need for an independent expert arises, for example, a representative from a specialist BME women's organisation, the chair will liaise with and if appropriate ask the organisation to join the panel.

3. If there are other investigations or inquests into the death, the panel will agree to either:

    a. run the review in parallel to the other investigations; or
    b. conduct a coordinated or jointly commissioned review where a separate investigation will result in duplication of activities.

Collating Evidence

1. Each agency is to search all their records outside the identified time periods to ensure no relevant information was omitted, and secure all relevant records.

2. The following agencies are to submit a chronology and IMR as per paragraphs 14 and 15:
    a. South Eastern Hampshire Clinical Commissioning Group on behalf of Bosmere Practice GP Surgery, Havant
    b. Adult Services, Hampshire County Council
    c. Portsmouth Hospital NHS Trust
    d. Havant Borough Council
    e. Hampshire Constabulary
    f. Somerset Care
    g. Southern Health NHS Foundation Trust
    h. NHS Ambulance Service

3. Each agency must provide a chronology of their involvement with Barbara C and Owen C during the relevant time period.

4. Each agency is to prepare an Individual Management Review (IMR), which:
    a. sets out the facts of their involvement with Barbara C and/or Owen C;
    b. critically analyses the service they provided in line with the specific terms of reference;
    c. identifies any recommendations for practice or policy in relation to their agency, and
    d. considers issues of agency activity in other boroughs and reviews the impact in this specific case.

5. Agencies that have had no contact should attempt to develop an understanding of why this is the case and how procedures could be changed within the partnership which could have brought Barbara C or Owen C into contact with their agency.

Analysis of findings

1. In order to critically analyse the incident and the agencies' responses to the family, this review should specifically consider the following six points:
    a. Analyse the communication, procedures and discussions, which took place between agencies.
    b. Analyse the co-operation between different agencies involved with the victim, perpetrator, and wider family.
    c. Analyse the opportunity for agencies to identify and assess domestic abuse risk.
    d. Analyse agency responses to any identification of domestic abuse issues.
    e. Analyse organisations access to specialist domestic abuse agencies.
    f. Analyse the training available to the agencies involved on domestic abuse issues.

Liaison with the victim's and perpetrator's family

1. The family of Barbara C should be sensitively involved in the review, if it is appropriate to do so in the context of on-going criminal proceedings. The possibility of making contact with the perpetrator who may be able to add value to this process should also be explored. The chair will lead on family engagement with the support of the Senior Investigating Officer and the Family Liaison Officer.

2. This should be coordinated with any other review process concerned with the child/ren of the victim and/or perpetrator.

Development of an action plan

3. Establish a clear action plan for individual agency implementation as a consequence of any recommendations.

4. Establish a multi-agency action plan as a consequence of any issues arising out of the overview report.

Media handling

5. Any enquiries from the media and family should be forwarded to the chair who will liaise with the CSP. Panel members are asked not to comment if requested. The chair will make no comment apart from stating that a review is underway and will report in due course.

6. The CSP is responsible for the final publication of the report and for all feedback to staff, family members and the media.

Confidentiality

7. All information discussed is strictly confidential and must not be disclosed to third parties without the agreement of the responsible agency's representative. That is, no material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.

8. All agency representatives are personally responsible for the safe keeping of all documentation that they possess in relation to this DHR and for the secure retention and disposal of that information in a confidential manner.

9. It is recommended that all members of the Review Panel set up a secure email system, e.g. registering for criminal justice secure mail, nhs.net, gsi.gov.uk, pnn or GCSX. Confidential information must not be sent through any other email system. Documents can be password protected.