



Domestic Homicide Review Overview Report:

EXECUTIVE SUMMARY

Adult Z

Born: July 17, 1955
Died: December 31, 2011

Tony Blockley
Director: Johnston and Blockley Ltd

November 15, 2013

Executive Summary

1. The review process

This executive summary outlines the process undertaken by The Safer Rotherham Partnership domestic homicide review panel in reviewing the circumstances of the death of Adult Z at the hands of her husband, Adult 1. Criminal proceedings have been completed; Adult 1 has been convicted of manslaughter and sentenced to 8 years imprisonment.

The couple met and married in 2000 and a year later bought a house together in Thurcroft, South Yorkshire. On 26th December 2011, they went to a party together. On the way home they had an argument which spilled over to the following day. The argument escalated and Adult 1 said that as he was trying to pour some white spirit on some clothing to spoil it, some of the spirit got onto Adult Z's clothing and caught fire. Adult Z received serious burns to her upper body and face and despite the best efforts of hospital staff, she died at 1.20pm on 31st December 2011.

On January 4, 2012, the Safer Rotherham Partnership determined that the Adult Z's death appeared to warrant the establishment of a domestic homicide review.

The following agencies were asked to provide chronological accounts of any contact they had with Adult Z, Adult 1 and any children they had been involved with in the 5 years prior to Adult Z's death:

- South Yorkshire Police
- The Village Surgery, Thurcroft, Rotherham
- Independent Domestic Violence Advocacy
- Choices and Options (a specialist Domestic Abuse support service)
- Rotherham Women's Refuge
- Apna Haq (The local Black Minority and Ethnic Refugee specialist support project for victims of domestic abuse)
- Rotherham Doncaster and South Humber (RDASH) – Mental Health
- RDASH – SMU (Clearways, the area substance misuse service)
- RDASH – (Lifeline, a service specifically dealing with alcohol misuse)
- Sexual Assault Referral Centre
- Rotherham Children's and Young People's Services
- North Lincolnshire Children's and Young Person's Service
- Rotherham Youth Offending Services
- Rotherham Metropolitan Borough Council Neighbourhoods and Adults Directorate
- Crown Prosecution Service
- HM Court Services
- The Children and Family Court Advisory and Support Service
- Victim Support Rotherham
- The Rotherham Foundation Hospital Trust

All of the agencies responded. There was no recorded history of domestic violence or abuse between the couple; of the agencies listed above, they were known only to the South Yorkshire Police, their General Practitioner and the Local Hospital Trust but not in a context of violence or abuse.

Those agencies produced reports covering the following:

- A chronology of interaction with Adult Z and with Adult 1;
- What was done or agreed;
- Whether internal procedures were followed; and
- Conclusions and recommendations from the agency's point of view.

The police

The police report shows that between 2002 and 2008, Adult Z made two reports of theft, two of youths causing a nuisance and one of a vehicle being found burnt out. She was also given a police caution for failing to report a road traffic accident.

The police had contact with Adult 1 between 1971 and 1980 for offences of dishonesty; he was convicted of five offences of burglary and was either fined, given a supervision order or a community service order. The police had no further contact with him until he telephoned them to say his wife had been admitted to hospital with severe burns.

The GP

The couple had contact with their GP before Adult Z's death, but not in respect of anything to do with domestic abuse or violence, substance misuse or mental health issues. Adult 1 saw his GP in January 2012 (after the incident) because he was having difficulty sleeping.

Local Hospital Trust

Their only involvement with either Adult Z or Adult 1 was after Adult Z had been admitted to hospital after the incident that led to her death.

2. Key issues arising from the review

There was an issue about a lack of a referral by the police to trigger the MARAC or IDVA processes and the fact that a 'near miss' policy that was in the development stage at the time was not invoked by the police or medical staff. The only agency not using the DASH risk assessment tool was the South Yorkshire Police. Had the risk assessment been undertaken using it, based on the accounts given at the time of the Adult Z's hospital admission, the level of injury sustained and the use of professional judgement, the risk would have been assessed as 'high' and MARAC and IDVA referrals would have been triggered.

Note: All the agencies had agreed that 'near miss' incidents would be referred during the development phase of the policy.

While considering issues around the 'near miss' policy, it was acknowledged that a case involving an attempted suicide following a history of domestic abuse should be referred if it gives rise for concern about the way local professionals and services work together to safeguard victims of domestic abuse. The question arose as to whether the term 'death' within the statutory DHR guidance includes instances of suicide where domestic abuse issues were or were suspected to have been an issue prior to the death.

Medical staff did not notify the police of their suspicions about how Adult Z's injuries had been caused, but they did tell Adult 1 to contact the police himself. (They assured the panel that they would have contacted the police themselves had Adult 1 not done so.)

Some training needs were identified within The Rotherham NHS Foundation Trust about risk assessment and domestic abuse awareness. Also identified was an issue about suspicions of abuse not being escalated to senior managers.

An issue was also identified about national guidance that currently exists in respect of the reporting of injuries by medical professionals without the consent of the victim. Currently, the guidance is that gunshot and knife injuries can be reported, but there is nothing in the guidance in respect of life threatening injuries caused by other means.

During the review process, an approach was made by the police family liaison officer to the Victim Support National Homicide Service for assistance. At that time, the criminal investigation was still ongoing and Adult 1 was insisting that Adult Z's death had been caused as a result of a tragic accident. Although a homicide had undoubtedly been committed, Victim Support felt they could not accept the referral because it had not been established that a criminal act had been involved.

3. Conclusion from the review

Neither Adult Z nor Adult 1 was known to any agency in a domestic abuse context and there is no suggestion that the tragic death of Adult Z could have been anticipated or prevented.

4. Recommendations from the review

National

- Consideration should be given to the national guidance for reporting gunshot and knife injuries without the consent of the victim being reviewed with a view to including life threatening injuries caused by other means.
- The Home Office is invited to consider the current 'near miss' policy identified by the Safer Rotherham Partnership for wider dissemination and implementation.
- The Home Office is invited to consider the provision of greater clarity around

the definition of a DHR to include victim suicide and serious injury.

- At a national level, consideration given to the Victim Support National Homicide Service funding and policy, with particular reference to engagement following criminality and clearer guidance as to what constitutes a 'homicide'.

Safer Rotherham Partnership

- The Safer Rotherham Partnership is well aware that raising public awareness of domestic abuse is an on-going process. The partnership should be clear that Domestic Abuse is wider than physical violence and should include all types of abuse, including coercive control. It should also include that abuse is age neutral affecting both women and men. The public awareness programme should be delivered regularly throughout the year and be accessible to all. It should be examined to ensure it identifies all aspects of abuse and that it can deliver appropriate outcomes.
- The Safer Rotherham Partnership 'near miss' policy should be updated to require immediate notification to the DAPG via the DAC rather than delaying referrals to the next scheduled meeting.
- The SRP MARAC Protocol and near miss protocol should be updated and explicitly state the need to share information where there is an indication of serious injury and professional judgement indicates this should be assessed as high risk should be referred to MARAC and IDVA without delay.
- In the absence of national guidance, the Safer Rotherham Partnership should develop a local protocol to ensure life threatening injuries caused by other means are identified and highlighted appropriately.
- IMR author training should be provided to all agencies within the Safer Rotherham Partnership and to 3rd sector organisations. The training should include critical analysis as a key component.
- DAPG should continue to pursue the development of a performance management framework.
- The Health and Well Being Board should commission a scrutiny review of domestic abuse support provision by cabinet members.
- Inevitably, when organisations differ on the identification, assessment and level of service provided there is a greater chance that potential victims and perpetrators will be overlooked and opportunities to intervene will be missed. There should be a standardisation within the Safer Rotherham Partnership of risk assessment processes including risk assessment tools.
- Domestic Abuse training for all agencies within the Safer Rotherham Partnership should include what to do in the event of negative disclosure and that further information re Domestic Abuse is available to all staff via its

website.

Individual Agency

- South Yorkshire Police should review their assessment process and provide further training and/or awareness for staff.
- Domestic Abuse training for the Rotherham NHS Foundation Trust should include what to do in the event of negative disclosure and that further information re Domestic Abuse is available to all Trust staff via its website.
- The Trust's training programme for Band 6 and above A&E staff in undertaking DASH risk assessments should be completed.
- The Trust should give active support to A&E staff undertaking DASH risk assessments and their domestic abuse policy should be revised to reflect negative disclosure.