Domestic Homicide Review Overview Report for

South and Vale Community Safety Partnership

EXECUTIVE SUMMARY

In the early hours of Sunday 4 September 2011 the police were called to the home address of Mr and Mrs A by a friend, Ms D, who had fled from the family home, herself injured by Mr A. When the police arrived at the family home they found both Mrs A and her mother, Mrs B, to have suffered severe injuries. The Ambulance service was called to the scene and both women were pronounced dead at the scene of the attack.

Mr A was convicted of two counts of murder and one of attempted murder in May 2012. He was sentenced to two life sentences for the murders and to a 12 year sentence for the attempted murder with a minimum term in prison of 36 years.

As this was a domestic homicide a DHR was established in line with the Home Office Guidance that came into force in April 2011.

The primary focus of this DHR is in relation to Mrs A although we have learned as a DHR panel from talking with family members and from information that emerged at the criminal trial, that the relationship between Mr A and Mrs B was tense. We understand from the circumstances at the time of these killings that both Mrs B and Ms D intervened when Mrs A was attacked.

Considerations
The DHR considered the extent of Mrs A's engagement with services prior to the incident. There was no exceptional contact with health services by either her mother or father in law, and nor was there any contact with the police, health services or social services in respect of domestic abuse concerns.

The main contact was with health services through the primary care Mrs A and her children received in general practice, with maternity services and subsequently health visiting services. There was also some contact with A&E in two different hospitals and with Oxfordshire County Council Children's services immediately after the premature birth of the son in late 2009. We have considered the way in which these agencies shared information and coordinated their engagement as well as how they engaged with Mrs A as specific services.

There are a number of learning points identified in the Analysis section of this report that have been identified in the Individual Management Reviews (IMR) and in the recommendations that are to be implemented by the responsible agencies.

This panel has had the benefit of hindsight, of knowing what happened, and also of careful analysis of information that was disparate at the time agencies were working with Mrs A. So we have seen and know more than clinicians did at the time. Using this intelligence, in addition to the specific Learning points and recommendations we want to draw out the following general points.

There was very little consideration of the situation with the father of these children, and while this might be understandable because he was not in the country, it is also the case that Mrs A gave out conflicting messages about the nature of the relationship. What this case illustrates is the importance of health services understanding the risks that people face when they are subject to relationship stresses and the difficulty there can be in picking up subtle indicators of the threat of domestic abuse.

During her pregnancies, in particular the second one, Mrs A spent extended periods in Turkey which meant that engagement with maternity services was not as full as would have been desirable. Both the DHR panel and the IMRs identified concerns about the extent of consideration given to the possibility that Mrs A was subject to domestic abuse. We acknowledge and support the actions taken within the service, and we have made our first recommendation in relation to reinforcing the importance of having this discussion, and recording it, as a matter of routine with all expectant mothers.

It became apparent that communication between the health visiting service and primary care was inadequate by both services, and again we are reassured that actions have been taken to improve this. We have however chosen to make a specific recommendation which is in line with recent General Medical Council guidance to improve partnership working.

There were significant stresses within the family and we have as a DHR panel drawn on recent work within Oxfordshire and the Royal College of General Practitioners promoting greater awareness of the possible impact of increased risk generated by such stresses for both child protection and domestic abuse within families. In making this reference we do not imply that this incident could have been predicted. We have extrapolated from this circumstance to reinforce the importance in primary care of understanding the family context and the risk indicators for harm within the family group.

Mrs A had an on/off relationship with her partner, both before and after they were married, and it has subsequently emerged that he had threatened her in the few weeks that they lived together in this country prior to the incident. However, none of the agencies were aware of these threats, and from information gained in discussion with family and friends it does not appear that Mrs A had a sustained concern about any specific threats. Again, we extrapolate from this specific circumstance where it is unsurprising that wider concerns were not raised, and make an ambitious recommendation that awareness about the risks and importance in informing responsible agencies is promoted and sustained at a national as well as local level.

Learning Points in the IMRs and the Recommendations of this DHR

The S&VCSP may want to establish a means of assuring itself that the agencies charged with implementing both their own IMR recommendations, and those from this DHR will be reported to their responsible governance forums, and to provide information into the future showing progress on their implementation.

Recommendations

Recommendation 1

That the Oxford University Hospitals NHS *Trust reinforce to staff the importance in adhering to routine discussion and recording practices in regard to domestic abuse.*

Recommendation 2

GPs are required to undertake refresher Child protection training every three years.

Recommendation 3

That where there are known stresses and risks to vulnerable children and/or their parent(s) the GP must inform the health visiting service, and similarly, the health visiting service must inform the family's GP.

Recommendation 4

All Primary Health Care Teams to receive awareness raising information on the signs of domestic abuse, how to manage concerns and the importance of effective information sharing systems.

Recommendation 5

That at a national and local level efforts to promote a wider societal understanding of the risks of domestic abuse are sustained and improved, with an emphasis on the importance of relatives, friends and the wider community making third party referrals where domestic abuse is suspected.

Nick Georgiou
Independent Chair of the Domestic Homicide Review Panel

25 October 2012