# Wokingham Community Safety Partnership

# Domestic Homicide Review

# Anne August 2021

Parminder Sahota: Independent Chair and Author

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## Preface

The Independent Chair, Author, and Review Panel extend their sincere condolences to everyone affected by Anne's tragic death and gratefully acknowledge their efforts and support during this procedure.

The main objective of a Domestic Homicide Review (DHR), when domestic abuse or violence is known to have been reported in the relationship, is to allow lessons to be learned from the victim's death. Professionals must understand what happened in each case for lessons to be broadly and effectively conveyed. What needs to be done most importantly to decrease the likelihood of such a tragedy

The Chair appreciates the panel's time, patience, and cooperation and those who provided chronologies and material.

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## Section One – The Review Process

### 1.1 Introduction and agencies participating in the Review

1.1.1 This summary describes the steps taken by the Wokingham Domestic Homicide Review Panel to review a resident's death. The death took place in August 2021.

1.1.2 The victim was a 42-year-old White South African woman named Anne. Her husband and a friend found her hanged in her residence.

1.1.3 Anne's husband brought their children on holiday to Anne's brother without Anne in April 2021. Anne took an intentional overdose to end her life whilst they were away. She said she believed her husband had taken her children away and excluded her from her family.

1.1.4 In February 2022, following the Multi-Agency Statutory Guidance for Domestic Homicide Reviews (2016), the Wokingham Community Safety Partnership commissioned a domestic homicide review.

1.1.5 The independent chair was commissioned on the 30th of March 2022..

1.1.6 The panel convened for the first time with the chair on the 29th of June 2022 meeting a total of four times.

1.1.7 On the 10th November 2022. The review panel's final meeting was held. To complete the report and conclusions, consider the necessary steps to implement the recommendations and finalise the report.

1.1.8 Wokingham Community Partnership approved the completed report on the 17th November 2022

1.1.9 The process exceeded the six-month timeframe specified in the statutory advice due to the initial agreement for a rapid review, which the panel determined would necessitate a formal DHR to guarantee Anne's perspective would be heard.

1.1.10 Anne's husband, brother, parents, friends, and Coach were all involved in the review discussion. Anne disclosed to her friends that her marriage was breaking down and informed one friend she was concerned about how she would manage beyond the

marriage, as a mother and financially. Her friends were aware of the messages Anne's husband sent her, and most, although not all, perceived these as abusive.

1.1.11 According to one of Anne's friends and her coach, Anne was subjected to coercive and controlling behaviour. Anne's friends feared that the anxiety about having her children taken away negatively affected her mental health.

1.1.12 The following Individuals and agencies contributed to the review:

| Role | Organisation |
|---|---|
| Named Nurse | Berkshire Healthcare NHS Foundation Trust |
| Head of Safeguarding Children | Berkshire West NHS, part of BOB ICB |
| Service Development Manager | Berkshire Women's Aid |
| Lead Nurse Adult Safeguarding | Royal Berkshire NHS Foundation Trust |
| Safeguarding Practitioner | South Central Ambulance Service NHS Foundation Trust |
| Local Commander, Bracknell and Wokingham Local Police | Thames Valley Police |
| Service Manager – Safeguarding Children | Wokingham Borough Council |
| Domestic Abuse Coordinator | Wokingham Borough Council |
| Community Safety Manager | Wokingham Borough Council |
| Assistant Director Children's Services (Quality Assurance) | Wokingham Borough Council |
| Business Support Officer | Wokingham Borough Council |

1.1.13 Parminder Sahota is an independent author with ten years of experience in domestic abuse and safeguarding. Advocacy After Fatal Abuse provided the DHR Chair training in 2021. She has worked as a mental health nurse in the NHS for over 20 years. She currently serves as the NHS's Director of Safeguarding, Prevent, and Domestic Abuse Lead.

1.1.14 Parminder Sahota is independent of all agencies involved and had no prior contact with family members, friends or the Wokingham Community Safety Partnership.

1.2 Purpose and Terms of Reference: Key Lines of Enquiry

1.2.1 The statutory guidance sets out the purpose of domestic homicides reviews to:

- Establish the facts that led to the death in August 2021 and whether there are any lessons to be learned from the case about how local professionals and agencies worked together to safeguard Anne.
- Establish what lessons are to be learned from the death regarding how local professionals and organisations work individually and together.
- Identify these lessons, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change.
- Apply these lessons to service responses, including changes to inform appropriate national and local policies and procedures.
- Prevent domestic violence and related deaths and improve service responses for all domestic violence and abuse victims by developing a coordinated multi-agency approach to ensure that domestic abuse is identified and responded to at the earliest opportunity.
- Contribute to a better understanding of the nature of domestic abuse.
- Highlight good practice.
- Ensure that Anne’s voice is heard regarding her lived experiences and the impact of domestic abuse on her mental health. Allowing her journey to be told and identifying the lessons that may be learnt.

1.2.2 The panel members, expert witnesses, and advisors were all chosen by the review panel. The review's time frame was set to cover the months of April 2021 to August 2021. The panel agreed that this time frame accurately reflected the difficulties discovered during scoping and subsequent communication with agencies.

1.2.3 The panel agreed on which agencies must submit a comprehensive chronology and individual management review per Section 9 of the Domestic Violence, Crime and Victims Act 2004 (Revised 2016).

1.2.4 The panel agreed on eighteen Key Lines of Enquiry for this case.

1.2.5 The panel agreed that Anne's family and friends needed to be included to give a thorough account of her life.

## Section Two – Agency contact and information learnt from the Review.

2.1 Anne received input from the following agencies during the period under the review:

1. Royal Berkshire NHS Foundation Trust (Hospital) – Anne was admitted in April 2021 following an intentional overdose.
2. Berkshire Women's Aid: Anne was referred to this service by her private coach.
3. Berkshire Healthcare NHS Foundation Trust - Mental Health services review Anne whilst in Royal Berkshire NHS Foundation Trust.
4. South Central Ambulance Service: Three callouts to Anne; the crew raised a safeguarding adult concern and noted Anne was extremely underweight.
5. Thames Valley Police: Anne and her friends are concerned about domestic abuse. They raised a concern to Children's services concerning domestic abuse.
6. Twyford GP Surgery: Aware of Anne's overdose and the trigger for this.
7. Wokingham Borough Council, Adult Social care: Received the concern from the ambulance service. Anne did not meet the criteria as per the Care Act 2014, and the concern was closed.
8. Wokingham Children's Service: Children and Family Court Advisory and Support Service requested that Children's services complete an assessment.

2.2 Anne was the mother of three children, two of whom were in primary and one in secondary school. She was not currently working. She was, however, a self-employed speech therapist.

2.3 Anne took a significant overdose, requiring Intensive Care treatment in April 2021. She disclosed being a victim of domestic abuse to health services, children's social care and the police, describing emotional and controlling behaviour from her husband.

2.4 Anne did not return to the marital home after her hospital discharge. She initially stayed with a friend, and then her husband paid for her to rent her own house.

2.5 Anne had supervised contact with her children per the family court order, and her relationship with her eldest child was strained.

2.6 **Evidence of Domestic Abuse**

2.7 In March 2020, Anne reached out to a divorce coach. Anne stated that she felt trapped in her marriage. She disclosed financial concerns; since she had no income, she would

be unable to acquire a mortgage or rent a home. Anne revealed that her husband emotionally abused her and threatened to remove their youngest child from a private school since he knew she was close to him.

2.8 Anne's husband returned home from a trip away with the children to see Anne's brother and found Anne unconscious at home. A 999 call was made, and Anne was taken by air ambulance to the Royal Berkshire Hospital and admitted to the Intensive Care Unit.

2.9 Anne was assessed by the Psychological Medicine Service (a service provided by Berkshire Healthcare Trust based at the Royal Berkshire Hospital). Anne revealed that the overdose resulted from relationship issues and that her husband had taken their children to see her brother while excluding her. She felt alone and had no reason to live. Anne was recommended to self-refer to Berkshire Women's Aid by the service.

2.10 Anne advised Thames Valley Police, whilst she remained an inpatient of the Royal Berkshire Hospital, that she was financially controlled by her husband and was afraid to return home. They referred the concern to Children's services.

2.11 Anne informed the Royal Berkshire Hospital that she was scared to go home due to her husband and disclosed a history of verbal abuse. She was advised that the police would talk to her, and they, too, referred her to children's services.

2.12 The Coach identified the abuse as controlling and coercive control and, with Anne's consent, referred her to Berkshire Women's Aid in April 2021(post-overdose).

2.13 Anne had brief contact with Berkshire Women's Aid, which was focused on Anne's concern with obtaining accommodation. The court had denied an occupation order. When she had secured accommodation, she informed Berkshire Women's Aid and no longer had contact with their service.

2.14 Anne informed children's services that she has Berkshire Women's Aid support and instructed a solicitor regarding arrangements for the children.

## Section Three– Key Issues arising from the review

3.1 **Agencies' response to disclosures of Domestic Abuse**

3.2 Anne shared her domestic abuse experience with authorities with whom she had contact. However, Anne was not referred, and self-referral to domestic abuse services was advised. The Coach was the sole professional to seek Anne's permission before referring her to domestic abuse services. The police referred the domestic abuse concerns to children's services.

3.3 **Intersectionality and Domestic Abuse.**

3.4 Anne's privileged upbringing may have created social biases and affected whether services saw her as a victim of domestic abuse.

3.5 Intersectionality acknowledges the uniqueness of discrimination and oppression and considers everything that might marginalise someone, including gender, ethnicity, class, sexual orientation, physical handicap, etc.

3.6 The Centre for Research on Violence Against Women noted that the statistics concerning domestic abuse victims are extracted from accessible data, usually from Health and Social Care. They report that more financially secure women have access to private physicians; Anne had noted that her friend would support her in accessing a private psychiatrist. As a result of the available data, the numbers suggest that lower-income women are more at risk of Domestic Abuse.

3.7 It has been suggested that those from higher income households may 'hide behind a veil of silence… believe it's only happening to them. No one can hear you scream on a 3-acre lot.' Anne had reported she felt guilty, and other victims/survivors of domestic abuse had been through worse.

3.8 **Deliberate Self-Harm and Domestic Abuse.**

3.9 Four months before Anne's death by hanging, Anne had taken a substantial overdose. She identified to the services relationship issues as the cause of her self-injury.

3.10 **Coercion and Control**.

3.11 Anne had reported experiencing coercion and control from her husband; the Coach identified this and appropriately referred her to Berkshire Women's Aid.

## Section Four– Recommendations

Individual IMR Recommendations

### 4.1 Berkshire Women's Aid (BWA)

1. Anne disclosed Mental Health support needs and a recent suicide attempt shortly before she was referred for support. While there was evidence that support needs and available options were explored with the worker during this initial assessment, BWA would have hoped for more direct evidence of professional curiosity and discussions around relevant referrals or support agencies to be discussed. BWA are not clinically trained and does not provide clients with mental health support; however, they felt there was room in this case for a more detailed exploration of support options with the client.
   **Action**: all front-line staff have been offered two-day mental health first aid training.

2. Whilst there was good evidence of BWA procedures being followed regarding contact and assessment with Anne, there could have been potential improvement in some elements of recording and communication. For example, fortnightly contact was being completed, but BWA would have expected this arrangement to be documented within the case notes; one further contact attempt could have been made to Anne to finalise support and complete a closing risk assessment; good routine practice is to contact any allocated social worker if the client consents to this.
   **Action:** staff have been reminded of these responsibilities via a re-dissemination of BWA policies. Team training has been held on recording and evidencing contact and case note training.

### 4.2 Berkshire Healthcare Foundation NHS Trust (BHFT): Crisis Resolution Home Treatment Team (CRHTT) and Psychological Medicine Service (PMS – who are based at the Royal Berkshire NHS Foundation Trust))

1. Berkshire Women's Aid information should have been offered to the patient, and the service explained. The comments about feeling unsafe going home were not picked up, discussed in more detail or followed up. Also, PMS should have addressed these comments with Thames Valley Police (TVP) as there was an ongoing case with them. This will be shared with CRHTT and PMS staff.
2. There is no evidence that the safeguarding was followed up/checked, the referral had been made, and additional information should have been given about the reports of the coercive control comments.
3. The West Berkshire CRHTT should have completed risk triage on the first contact and ensured Anne felt safe from herself and her husband.
4. The plan on April 16th was to organise a medical review, but Anne was discharged without a formal medical examination; there is no explanation in the notes as to why she did not require one if it was part of the initial plan.
5. BHFT now have a domestic abuse champion within the team to ensure these issues will be identified in the future. These learning points will be discussed in the next CRHTT space group.

### 4.3 Royal Berkshire NHS Foundation Trust

1. Domestic Abuse Policy recommends routine questioning. Work is ongoing within the Trust to establish this, particularly in the admission areas.
2. Domestic Abuse Risk Assessment Identification Checklist (DASH) forms are also encouraged – more training is required.

### 4.4 South Central Ambulance Service NHS Foundation Trust

1. On review of the incidents, Anne received appropriate care.
2. The safeguarding referral completed on the 4th of April was missing details regarding the children, which would aid inter-agency working. A referral was made; however, there could be greater detail and information contained within the family dynamic and also consideration around why the incident had occurred, as well as a history.

### 4.5 Thames Valley Police

1. Although there is some learning from this incident, there does not appear to be a single failure or series of systemic failures that could have prevented this tragic incident.

There was a breach of policy in the delayed supervisor's review, and room throughout for more joined-up information and professional curiosity. These matters are, however, already under consideration through various processes.

2. Domestic Abuse remains a priority for Thames Valley Police at a force and local level. Thames Valley Police has clear performance targets around various aspects of Domestic Abuse, and Domestic Abuse forms a vital part of daily planning and management. Indeed, at a local level within Bracknell and Wokingham, each Domestic Abuse offence is reviewed as part of a daily management meeting Chaired by a senior management team member to ensure a suitable response.
3. There is ongoing training to improve TVP's response to Domestic Abuse. This is via the in-person training of 'Domestic Abuse Matters' and a continuing focus on this aspect of Policing within other training settings.
4. Investigation across all strands of Thames Valley Police is subject to the 'Endeavour' programme, aimed at improving investigative standards and developing the skills of our staff to identify opportunities to investigate all crime types successfully. More specifically, there is an appointed lead for Domestic Abuse with a portfolio covering this critical area and local Domestic Abuse champions to provide local support to encourage good practice in this area.

The review identified themes that may support practitioners in responding to adults presenting in similar circumstances to Anne. These have been used to support the following recommendations.

## Recommendations for the panel

### 4.6 Recommendation one: Agencies' Response to Domestic Abuse

Anne disclosed her experience with domestic abuse to every service she contacted. Anne was specifically referred to Berkshire Woman's Aid by the divorce coach.

1a Inclusion of the NICE Quality Standard (QS116) in service policies and procedures. Staff members within Health should be able to enquire about domestic violence and respond to disclosures.

1b For agencies to ensure they have an easily accessible system for practitioners to refer domestic abuse victims to resources and a process to ensure the domestic abuse discussion is documented.

1c When a victim/survivor of domestic abuse is discharged from services, the service provider must inform the appropriate professionals, including the referrer.

### 4.7 Recommendation Two: Intersectionality and Domestic Abuse

Womankind defines intersectionality as: 'Intersectionality is the acknowledgement that everyone has their own unique experiences of discrimination and oppression, and we must consider everything and anything that can marginalise people – gender, race, class, sexual orientation, physical disability, etcetera.

Anne, a White South African woman, explained that her parents were traditionalists who believed marriage should be worked on. Anne came from a wealthy household, her children attended private schools, and according to her mother, she had all she required. Her husband reported giving Anne £5,000 every month.

2a For organisations to ensure that their training incorporates the power dynamics of relationships and barriers to receiving services.

2b For organisations to examine their present domestic abuse responses and ensure that they enable practitioners to apply a customised response to the victim.

### 4.8 Recommendation Three: Deliberate Self-Harm and Domestic Abuse

Anne had taken a significant overdose in April 2021, leading to her admittance to the intensive care unit (ICU). Anne claimed that her overdose resulted from domestic abuse by her husband.

3a Organisations should review their present risk assessments and ensure they incorporate risk to self and, more critically, a collaborative risk management plan.

3b When self-harm/suicidal ideation is coupled with domestic abuse, agencies must have clear procedures for responding to the disclosure and providing the victim/survivor with the needed support. This may involve aiding the victim/survivor in self-referral or referring on their behalf.

3c It is recommended that all participating agencies consider the integration of suicide prevention and suicide first aid training in their safeguarding/domestic abuse training strategies.

### 4.9 Recommendation Four: Coercion and Control

Anne described experiencing coercion and control in her relationship, including emotional abuse, financial control, and threats to remove her children from private school and maybe the country.

4a Consider the draft guidance Controlling or coercive behaviour statutory guidance - GOV.UK (www.gov.uk) and ensure the partner agencies comply with the published guidance.

4b Agencies must ensure that their staff can identify coercion, control, and respond appropriately. Documentation should be readily available for staff to document and refer to issues and provide prompts to evaluate all components of domestic abuse.

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## Section five– Conclusions

5.1 The review focused on Anne's final months of life. During this period, Anne had taken two overdoses, one of which required admittance to the intensive care unit and the other of which she said was not deliberate.

5.2 Anne reported that her fear that her children would be taken away triggered the first overdose. She disclosed to authorities that she was a victim of domestic abuse, that she was afraid to return home, and that her husband was emotionally abusive, coercive, and controlling. Unfortunately, the agencies (Health, Social Care, and Police) did not obtain consent, discuss referral to a domestic abuse service, or do a DASH risk assessment.

5.3 In April 2021, the ambulance service raised a safeguarding adult concern following the overdose. Anne was cited as being extremely underweight and at risk of neglect. Adult Social Care closed the case because Anne did not meet the criteria outlined in Care Act 2014 Section 42.

5.4 Due to allegations of domestic abuse, Thames Valley Police reportedly sent a referral to Adult Social Care. Adult Social Care reported, however, that they had not received this referral.

5.5 To ensure that victims are responded to and supported to lessen the possibility of harm, it has been recommended that all agencies examine their response to domestic abuse and address self-harm and domestic abuse.

5.6 Anne revealed financial difficulties; she stated that she had no income and hence would be unable to obtain a mortgage or rent a home. She came from an affluent family but declared she did not know how she and her children would be supported.

5.7 To guarantee that services consistently respond to victims/survivors, a recommendation has been made to ensure that risk assessment and safety planning incorporate an understanding of each unique individual's background/experiences/ disabilities, which may place them at a disadvantage.

5.8 Domestic abuse is multifaceted and can take many forms. Anne had mentioned the hidden forms of abuse: emotional coercion and control. These abuses are frequently challenging to demonstrate to others, causing victims to feel unwilling to seek assistance or frightened that they will not be believed. When Anne disclosed domestic abuse, the Coach referred her to services for victims, and the Police referred her to Children Social Care.

**The overview report will not be published due to the potential harm this may cause the children.**