DOMESTIC HOMICIDE REVIEW
&
SERIOUS CASE REVIEW

Adult S and Child CC

EXECUTIVE SUMMARY

Elmbridge Community Safety Partnership
&
Surrey Safeguarding Children Board

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1. Executive Summary

1.1 Introduction

1.1.1 This executive summary outlines the process and findings of a joint domestic homicide and serious case review undertaken by Elmbridge Borough Council and Surrey Safeguarding Children Board into the killings of Adult S and Child CC. The identity of those involved has been anonymised for the purposes of confidentiality.

1.2 Outline of the incident

1.2.1 On 29 June 2015 the bodies of Adult S and Child CC were discovered in their Elmbridge home by Surrey Police. As Adult R took his own life there is no opportunity to prosecute him for any offence. However, the investigation by Surrey Police into the deaths of Adult S and Child CC resulted in a clear conclusion that Adult R was the perpetrator of both killings.

1.2.2 On 23 November 2015 HM Coroner for Surrey returned verdicts of unlawful killing in respect of Adult S and Child CC. The cause of Adult S's death was strangulation and the cause of Child CC's death was suffocation.

1.3 Domestic Homicide Reviews

1.3.1 Domestic Homicide Reviews (DHRs) were established under Section 9 (3), Domestic Violence, Crime and Victims Act 2004 and are conducted in accordance with Home Office guidance.

1.3.2 The purpose of this review is to:

(a) Establish what lessons are to be learned from 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 those lessons to service responses including changes to policies and procedures as appropriate.

(d) Prevent domestic homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

1.3.3 This review process does not take the place of the criminal or coroners courts nor does it take the form of a disciplinary process.

1.4 Serious Case Reviews

1.4.1 The Strategic Case Review Group of the Surrey Safeguarding Children Board agreed that the case meets the criteria for a proportionate serious case review (SCR), in accordance with the Working Together 2015 statutory guidance. The Independent Chair agreed a joined DHR/SCR process for this case.

1.4.2 The purpose of this review is to:

(a) Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children;

(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; and

(c) Improve intra- and inter-agency working and better safeguard and promote the welfare of children.

1.5 Terms of Reference

1.5.1 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.

1.6 Independence

1.6.1 The Chair of the Review was Anthony Wills, an associate DHR Chair with Standing Together against Domestic Violence. Anthony has conducted domestic abuse partnership reviews for the Home Office as part of the Standing Together team that created the Home Office guidance on DV partnerships, 'In Search of Excellence'. He was also Chief Executive of Standing Together from 2006 to 2013. He has undertaken the Home Office accredited training for DHR Chairs and also worked as a police officer for 30 years, concluding his service as a Chief

Superintendent. He has no connection with the Elmbridge Community Safety Partnership or the agencies involved in this review.

1.6.2 The Overview Report Writer was Jessica Donnellan, the Senior Projects Coordinator at Standing Together against Domestic Violence. Jessica has over ten years' experience working in the domestic violence and abuse sector. Jessica has no connection with the Borough of Elmbridge or any of the agencies involved in this case.

1.7 Parallel and related processes

1.7.1 There were no other reviews conducted contemporaneously that impacted upon this review.

1.8 Methodology

1.8.1 The approach adopted was to seek Individual Management Reviews (IMRs) for all organisations and agencies that had contact with Adult S, Child CC and Adult R. 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.

1.8.2 IMRs were provided by:

(a) Surrey Police

(b) Guildford High School

1.8.3 Additional information sought and reviewed by the Panel included patient records from:

(a) Littleton Surgery

(b) Bupa Cromwell Hospital

1.8.4 Agency members not directly involved with the victims, perpetrator or any family members undertook the IMRs.

1.8.5 The Review Panel members and Chair were:

(a) Anthony Wills, Chair, Standing Together against Domestic Violence

(b) Karen Laurie, Pastoral Deputy Head, Guildford High School

(c) Jane Lord, Major Crime Review Group, Surrey Police

(d) Chris Edwards, Public Protection, Surrey Police

(e) Elaine Coleridge, Independent Chair, Surrey Safeguarding Children Board

(f) Anastasia Drenou, Serious Case Review Administrator, Surrey Safeguarding Children Board

(g) Robert Moran, Chair, Elmbridge Community Safety Partnership

(h) Annabel Crouch, Policy Officer, Elmbridge Borough Council

(i) Philip Gavins, Adult Safeguarding Lead, Littleton Surgery

(j) Gill Kendle, Service Manager, North Surrey Domestic Abuse Outreach Service

(k) Vernon Nosal, Interim Strategic Head of Safeguarding and QA, Surrey County Council

1.8.6 The Chair wishes to thank everyone who contributed their time, patience and cooperation to this review.

1.9 Contact with family and friends

1.9.1 The Chair sought contact with Adult S and Child CC's families through the Surrey Police Family Liaison Officer (FLO). Contact with Adult R's family was sought via the Investigating Officer in the case.

1.9.2 All close relatives were contacted by the FLO and written to separately by Standing Together. One relative initially accepted the offer of a meeting to discuss the review but then cancelled that meeting. Subsequent attempts to arrange a new date have not been successful.

1.9.3 A work colleague of Adult S was contacted but declined to participate. The personal assistant for the family did agree to meet with the DHR chair and overview report writer and provided some useful background information.

1.9.4 The panel considered speaking to Child CC's close friends from school. They had provided extensive and detailed statements to the police which were very helpful in establishing some understanding of Child CC's character. The panel decided, after some debate, that a further meeting with them would be unnecessary as they had been so informative and they would have been repeating what had clearly been a painful process.

1.10 Summary of the case

1.10.1 Adult S was 47 years old at the time of her death and was self-employed, working with Adult R in corporate hospitality. Child CC was their only child and was 14 years old at the time of her death. During the Review Terms of Reference timeframe, they had contact with:

(a) Surrey Police on four occasions: on 05 September 2010 when Adult S reported that Adult R had been the victim of a road rage incident; on 18 December 2014 and 03 March 2015 when a vehicle registered to Adult S was recorded by speed cameras driving at excess speed; and on 31 July 2012 when Adult S telephoned Police in relation to domestic abuse.

(b) Guildford High School, the educational establishment that Child CC had attended since 2008 where staff described Child CC as 'a lovely, kind and caring girl' and her parents as protective, sometimes over-protective, of her.

(c) Their NHS General Practitioner: in relation to Adult S's three suspected urinary tract infections (UTIs) between September 2012 and May 2014; and Child CC's three presentations with injuries (February 2013, September 2013 and June 2014), each seemingly accompanied by credible causal explanations.

(d) Bupa Cromwell Hospital on four occasions with Child CC: in January 2011 she had an outpatient appointment with an adult chest physician, in March 2011 she was a general paediatric inpatient overnight, in September 2012 she had a paediatric outpatient appointment with an allergist and in November 2012 she had a paediatric outpatient appointment with a general paediatrician. Child CC had been diagnosed with "leaky gut syndrome" (LGS) and this caused the Panel significant concern as it is not an illness generally recognised by medical practitioners.

1.10.2 The contact between Adult S and Surrey Police in July 2012, when Adult S sought help in relation to domestic abuse, has identified learning opportunities in relation to:

- Advice giving
- Improving the whole workforce's understanding of risk identification and escalation

- Identifying children in households where there is known domestic abuse and disseminating relevant information to schools
- Respecting and listening to survivors of domestic abuse as expert in risk identification / escalation
- Understanding where the agency's line of accountability lies and the need to activate other parts of a wider system to help, particularly specialist domestic abuse support services.

1.10.3 Throughout the six and a half years that that Child CC attended Guilford Junior and High Schools, the schools received no obvious evidence to alert them to the possibility that Child CC was living in a household where there was domestic abuse. Guildford High School is keen to consider more active ways in which it can encourage and initiate dialogue around domestic abuse and publicise ways that children and young people can make disclosures.

1.10.4 The Chair felt that the NHS GP could have enquired with Adult S about domestic abuse following her repeat presentations with UTIs. Indeed, there is an appetite for the IRIS[1] (Identification and Referral to Improve Safety) programme to be rolled out in Elmbridge to support GPs to improve practice in relation to domestic abuse.

1.10.5 The sparse information provided to this Review by Bupa Cromwell Hospital does not provide adequate context or detail to identify whether Child CC disclosed any information that could have reasonably triggered enquiry around domestic abuse. The Panel questioned whether the symptoms Child CC was experiencing could have been psychosomatic, caused by the stress of living in an abusive household.

1.11 Key issues arising from the Review

1.11.1 The precise nature of domestic violence and abuse is well known to those agencies who so regularly deal with victims, their children and perpetrators. The

[1] http://www.irisdomesticviolence.org.uk/iris/

evidence of many DHRs is that opportunities nearly always exist where a different approach could have led to opportunities being grasped where the fatal outcome could have been averted. In this sense that is true in this case and, if preventability is defined in its widest sense, there is a possibility that the deaths of Adult S and Child CC could have been prevented.

1.11.2 This case highlights how fleeting and limited such opportunities can be. There should be no avoiding of the fact that in some way the police, the school and the GP practice in this case can now enhance their practice to consider whether domestic violence is present, what level of risk is posed and what action can be taken to mitigate that risk and support the vulnerable. This is the true benefit of DHRs and the recommendations will lead to a more responsive, aware and effective practice within a coordinated response.

1.11.3 With this in mind this case also illustrates the difficulty of predicting such events. The time lapse between the one report of domestic abuse and the deaths shows how difficult it is to assess the outcome of abusive relationships. On the evidence available it cannot be said that these killings were predictable, although that must never obscure the fact that such abuse is almost always accompanied by the dynamic of escalation and that the abuse or violence will worsen.

1.12 Conclusions

1.12.1 There is a paucity of information about the true nature of the relationship between Adult R, Adult S, and Child CC. Whilst it is known that Adult S had reported domestic abuse in 2012 and that they were in financial difficulties there is very little evidence on which to base strong and detailed conclusions. This, though, is often the nature of domestic relationships which are abusive. It is for this reason that the level of intervention and the expertise necessary to deal with such matters is the subject of much consideration, training, policy and practice. It is only through agencies working together, in a Coordinated Community Response, that such improvements can be achieved.

1.12.2 According to the policies of the time (especially in the case of the police in 2012) this case was dealt with in a “standard” way. This is a vast improvement from earlier times but this review amply demonstrates that development is still necessary. The recommendations below are designed to build upon changes that have been instituted and become commonplace and also take the agencies to the next level where the prevalence of domestic violence or abuse and its nature are

addressed more comprehensively and with the improved understanding of its dynamics.

1.13 Recommendations

1.13.1 Reports on progress against recommendations should be made to the Elbridge Community Safety Partnership and the Surrey Safeguarding Children's Board.

1.13.2 **Partnership Arrangements**

1.13.3 Recommendation 1 - That the CSP analyse their existing response to domestic abuse and seek to develop a more complete and enhanced approach to this issue through the mechanism of a Coordinated Community Response to domestic abuse.

1.13.4 Recommendation 2 – Develop and trial individual and community interventions using the concept of co-production, to enhance the borough's response to victims of domestic abuse.

1.13.5 Recommendation 3 – Ensure that the agreed intention of providing Police information about vulnerable people to relevant agencies, including schools is promulgated with urgency.

1.13.6 Recommendation 4 – Undertake a cost-benefit analysis to establish the viability of implementing an additional referral pathway between police and NSDAS in cases where the DASH risk assessment system has not been successfully completed.

1.13.7 **Surrey Police**

1.13.8 Recommendation 5 – Deliver training for Contact Centre staff to ensure a sound grasp of the dynamics of domestic violence and to equip them with the skills and information necessary to respond appropriately to victims of domestic abuse.

1.13.9 Recommendation 6 – Develop for all frontline staff (including staff in contact centres and control rooms) clear referral pathways to specialist domestic abuse support services and related agencies.

1.13.10 Recommendation 7 – Provide enhanced risk identification and awareness training for Public Protection Unit supervisors.

1.13.11 Recommendation 8 – Surrey Police to use this DHR process and the development from the recommendations to audit its policies and practice to

ensure the developments are embedded in practice (within 6 months of publication of the report).

1.13.12 **Guilford High School (GHS)**

1.13.13 Recommendation 9 – Integrate domestic abuse awareness into safeguarding training for all staff (and ensure those staff already trained in safeguarding receive this training).

1.13.14 Recommendation 10 – Integrate the Spiralling[2] toolkit into PSHE (personal, social, health and economic) education.

1.13.15 **NHS General Practice in Elmbridge**

1.13.16 Recommendation 11 – Request the Joint Commissioning Board to commission the IRIS programme within the area.

1.13.17 **National Recommendations**

1.13.18 The CSP should be informed of the outcome of the following recommendations which go beyond a purely local remit.

1.13.19 Recommendation 12 – Debt advisory services to develop a system where those individuals with County Court Judgements (or similar) relating to debt are provided with information about domestic abuse support services and support to assist in the resolution of the case.

1.13.20 Recommendation 13 – HM Government to develop the statutory guidance for DHRs to specifically include private medical care and oblige such organisations to participate in the DHR process.

1.13.21 Recommendation 14 - NHS England to respond to the gaps that emerge between private and national health care providers which may threaten the safety of adult and child survivors of domestic abuse.

[2] https://www.tamesidesafeguardingchildren.org.uk/resources/materials/toolsandresources/spiralling/spiralling_toolkit.pdf