Safe in the city
Brighton & Hove Community Safety Partnership

STANDING together
against domestic violence

Domestic Homicide Review relating to the death of Mr C

Executive Summary

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Executive Summary

Summary of the Incident

1. The incident

1.1. On Monday, 16 July 2012, AC, Mr C's older sister who lives in [redacted], rang Sussex Police saying that they had not heard from her brother, Mr C (60-64) for two months. Mr C had spoken to one of his sisters, BC, on 14 May 2012 and was last seen alive by a friend, LM, on 23 May 2012.

1.2. Police attended Mr C's home and found Mr C's decomposed remains on his bed and covered with a sheet. There was no evidence of a forced entry, burglary or a violent altercation.

1.3. Initially, the death was not treated as suspicious[1], but the Coroner's preliminary enquiries into Mr C's medical history identified that he had been taken by ambulance to the Royal Sussex County Hospital (part of Brighton and Sussex University Hospital Trust (BSUH)) on 14 May 2012 after collapsing in a store and telling staff there that he had been assaulted by his boyfriend. This information was passed to the Sussex CID and then to the Major Crime Team.

1.4. A post mortem concluded that Mr C had died from blunt force trauma to his body and a homicide investigation began on 21 July 2012.

2. Criminal trial

2.1. Mr Y, Mr C's flatmate, was sought but not found until 7 May 2013, when he was arrested.

2.2. Mr Y was indicted for murder. When the jury were sent out to consider their verdict they were told that they could consider both murder and manslaughter by the Judge. Mr Y was convicted of manslaughter, causing

[1] This report addresses activity with services up to the time of Mr C's death. However, it is worth noting that, as it is difficult to ascertain the cause of death of a decomposing body, police might consider such a death suspicious from the outset.

actual bodily harm, and preventing a decent lawful burial on [redacted] and sentenced to 18 and a half years. A deportation order was also made. During this DHR, Mr Y has requested leave to appeal his conviction and his sentence. He has been given leave to appeal his sentence, but not his conviction.

The Review Process

3. Process

3.1. This Domestic Homicide Review (DHR) was commissioned by the Safe in the City Partnership, Brighton & Hove's community safety partnership, in accordance statutory with the Revised Statutory Guidance for the conduct of Domestic Homicide Reviews published by the Home Office in March 2013.

3.2. Sussex Police notified the Safe in the City Partnership on the 29 May 2013 that the case should be considered as a DHR (the reason for the time delay is outlined in 1.4 and 1.5). The Safe in the City Partnership made a decision to conduct a DHR, and having agreed to undertake a review, the Home Office was notified of the decision on the 11 July 2013. An initial meeting was held on the 19 August between representatives from the Safe in the City Partnership and Sussex Police to establish the scope of the DHR, as well as to identify how it would dovetail with the then ongoing criminal investigation. At this time it was agreed that the review was not to be fully commenced until the conclusion of criminal proceedings.

3.3. The Safe in the City Partnership appointed Laura Croom, an Associate of Standing Together Against Domestic Violence to chair the review. Standing Together is an organisation dedicated to developing and delivering a coordinated response to domestic abuse through multi-agency partnerships. The Associate has no connection with Brighton & Hove City Council or any of the agencies involved in this case.

3.4. The purpose of this review is to:

3.4.1. Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

3.4.2. 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.

3.4.3. Apply those lessons to service responses including changes to policies and procedures as appropriate.

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

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

3.6. The initial Panel meeting was held on 21 October 2013 to consider the circumstances leading up to this death, with subsequent Panel meetings on 22 January 2014, 9 April 2014 and 20 May 2014.

3.7. The Executive Summary and Overview Report, as well as recommendations in response to the findings, were presented Violence against Women and Girls (VAWG) Programme Board in September 2014. The Safe in the City Partnership Board also received a report on these recommendations in the same month, as part of the city's combined action plan. They were submitted to the Home Office in September 2014 and were considered at the November meeting of the Home Office Quality Assurance Panel. The report was judged 'adequate', with the Home Office providing notification and approval for publication in December 2014.

3.8. Once published, the final report will be shared with the governance boards and committees of participating statutory agencies; in addition an Executive Summary will be shared with the Violence against Women and Girls Forum in Brighton & Hove.

4. Terms of Reference

4.1. The purpose 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.

4.2. The time frame agreed was the time that Mr C had lived in Brighton, i.e. from October 2011 until his death in late May or early June 2012, but information was sought from agencies he and Mr Y might have had contact with in [redacted] before that date. Mr C's [redacted] GP and his previous employers responded to requests for information from before October 2011.

5. Parallel and related processes

5.1. On [redacted], Her Majesty's Coroner for Brighton & Hove held an inquest into the death of Mr C and concluded: '*So, taking everything that I've heard into consideration, I am satisfied beyond reasonable doubt that [Mr C] was unlawfully killed and that's the verdict that I am recording.*'

5.2. The criminal trial of Mr Y was concluded on [redacted]

5.3. There were no parallel reviews undertaken in the course of this review.

6. Panel Membership

6.1. The Panel were:

- Brighton and Sussex University Hospital NHS Trust (BSUH)
- Sussex Police, Crime Review Team
- RISE – local specialist domestic abuse service, with representation from the LGBTQI[2] service within the organisation
- Brighton & Hove Clinical Commissioning Group
- Sussex Partnership Foundation Trust, with substance misuse and mental health responsibilities
- Brighton & Hove City Council, Safeguarding Adults and Partnership Community Safety Team (including the Head of Community Safety and the Violence against Women & Girls Commissioner).

7. Independence

[2] Lesbian, Gay, Bi-sexual, Transgender, Queer, or Intersex

7.1. The Independent Chair of the DHR is Laura Croom, an associate of Standing Together Against Domestic Violence, an organisation dedicated to developing and delivering a coordinated response to domestic abuse through multi-agency partnerships. She has conducted domestic abuse partnership reviews for the Home Office as part of the Standing Together team that created the Home Office guidance on domestic violence (DV) partnerships, 'In Search of Excellence'. She undertook the Home Office accredited training for DHR Chairs and has worked in domestic abuse for over 10 years. She has no connection with the Brighton & Hove City Council or any of the agencies involved in this case.

8. Agencies participating in this review

8.1. Requests for a 'Summary of Involvement' (SOI) with Mr C or Mr Y were sent to ten agencies in [redacted], where the two men had lived before moving to Brighton in October 2011, and to ten agencies in Brighton & Hove. Where there was no involvement or insignificant involvement, agencies advised accordingly.

8.2. Based on the response in the SOI, Individual Management Reviews (IMRs) were requested from those organisations and agencies that had contact with Mr C or Mr Y.

8.3. These requests are summarised below, with those agencies that provided a full Individual Management Reviews (IMRs) indicated with asterisks:

- [redacted] police – information provided through Sussex Police*. Contextual information.
- [redacted] GP – Mr C's GP for 38 years. Last saw Mr C in July 2011.
- [redacted] NHS Trust – Mr C's employer from 29 April 1996 to 6 April 2011.
- [redacted] Homeless Options Team – provided both address details
- Brighton GP* – minimal. Mr C registered there but never attended a GP.
- South East Coast Ambulance Service* – called to Mr C 3 times in the 7 months before he died. Last call out on 14 May 2012.

- Brighton and Sussex University Hospital NHS Trust* – Mr C brought by ambulance to the hospital on 2 occasions in the 4 months before he died. The last attendance was on 14 May 2012.
- Brighton store – the site of Mr C's collapse on 14 May 2012 before he was taken to hospital.

8.4. Agencies who had no contact

- [redacted] Centre
- [redacted] Probation
- [redacted] Health Trust
- [redacted] Safeguarding Adults
- [redacted] Homeless and Anti-social Behaviour Teams
- RISE, specialist domestic abuse service in Brighton and Hove (B&H)
- Sussex Probation
- Sussex Partnership Trust
- B&H Safeguarding Adults
- B&H Homeless Options Team.

9. Individual Management Reviews

9.1. Agencies were asked to give chronological accounts of their contact with the victim prior to his death. Each agency's report covers:

- 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

10. Contact with family and friends

10.1. In accordance with the Statutory Guidance, the panel sought to engage with Mr C's family. The Family Liaison Officer (FLO) passed the Chair's letter explaining the purpose of the DHR to a member of Mr C's family. Subsequently, members of the family agreed to meet with the Chair and FLO in early January 2014.

10.2. The Chair and the FLO met with 7 members of Mr C's family in January 2014. A brother who was unable to attend that meeting sent an email with his observations and further questions.

10.3. A number of Mr C's family had attended the trial and several had given evidence.

10.4. The Chair met with 4 members of Mr C's family in early September to review and comment on the draft report the draft report before it was sent to the VAWG Programme Board, the Safe in the City Partnership Board or the Home Office and their responses are included. Their responses are included in the body of the report.

10.5. Contact with friends of Mr C was not sought as they were witnesses in the criminal justice proceedings throughout the course of this review.

10.6. Contact with members of Mr C's wider network was also attempted, specifically with his former employer.

10.7. Contact with the perpetrator has not been sought as he was the subject of criminal justice proceedings throughout the course of this review, first with his trial and then an appeal.

The Facts

11. Summary of the Case

11.1. The relationship between Mr C and Mr Y was ambiguous. They met in 2009 when Mr C answered an ad posted by Mr Y [redacted]. They began an on-off relationship from that time and Mr Y lived with Mr C on an occasional basis though did not appear to contribute money to the household. Mr C told his family that he and Mr Y were partners. Mr Y described himself to professional staff as a friend and then a carer for Mr C.

11.2. Mr C had lived in [redacted] for many years with his previous partner who died in 2001. He moved to Brighton in October 2011 in order to live a more openly gay life. Mr C moved with him.

11.3. Mr C had a number of chronic health problems that meant he saw his GP in [redacted] regularly. Though he moved to Brighton in October 2011, he did not register with a GP there until February 2012 and did not attend that surgery to see a doctor before his death.

11.4. An ambulance was called for Mr C on 30 October 2011, 20 February 2012 and 14 May 2012. He had fainted or collapsed on these occasions.

11.5. On the first occasion, Mr C was not taken to hospital as he recovered while the ambulance crew were with him.

11.6. On the second and third occasion he was taken to hospital. On the second occasion, he was seen by several teams to address his injuries and his long-term alcohol dependence.

11.7. On the last occasion, on 14 May 2012, he was in a store when he collapsed. He told the staff at the store and then the ambulance crew that his boyfriend had hit him. He was transported to hospital where Mr Y joined him. When Mr Y arrived at the hospital, Mr C told the triage nurse, 'He beats me up'.

11.8. As Mr C was not in need of emergency medical attention, he was directed to the waiting room where he sat with Mr Y to be seen by a doctor. When he was called two hours later to be seen by a doctor, he had left the hospital.

11.9. Mr C's body was found on 16 July 2012. The post mortem concluded that Mr C had died form blunt force trauma to his body. The pathologist noted injuries of various ages, most having happened within 12 hours of Mr C's death.

Key Issues Arising from the Review

12. Lack of understanding in the community

12.1. Victims often find it difficult to name the abuse they are suffering. Mr C's family knew that Mr C was suffering domestic abuse but they could not engage him in a conversation about it. The Review identified the need for local information for:

- victims and survivors tailored for specific communities so that they are able to name the abuse
- family and friends of victims/survivors so they know where to go for advice and information

12.2. Employers may see signs of abuse in the behaviour of their employees. Employers and unions should be assisted to raise awareness among staff and members, know how to respond to concerns or a disclosure and offer proactive support.

13. Need for improved and consistent response from healthcare and substance misuse services

13.1. GP practices, and secondary health care, and in particular Accident & Emergency, and the ambulance service need to provide a consistent response to domestic violence and abuse. This requires staff to be trained so they have the confidence to recognise the indicators of domestic violence and abuse and can ask relevant questions to help people disclose their past or current experiences of such violence or abuse. Staff would also need to be aware of the services, policies and procedures locally and have access to a formal referral pathway to support a response to a disclosure.

13.2. The Panel also noted the need for staff in mental health, children's and vulnerable adults' services, sexual health, alcohol or drug misuse, antenatal, postnatal, reproductive care, to ask service users whether they have experienced domestic violence and abuse. These services work with people with particular risks or vulnerabilities that may make it hard for them to disclose, whose symptoms of abuse may be masked by other issues or mistakenly attributed to another cause. This should be a routine part of good clinical practice, even where there are no indicators of such violence and abuse.

13.3. Not only do practitioners need to ask, but there needs to be a consistent response to domestic violence and abuse within both health care and substance misuse settings. In addition, the Panel felt that an effective response to domestic violence and abuse in all commissioned services would be supported by ensuring that Commissioners are aware of the city's Service Level Outcomes for Violence Against Women & Girls and that these are reflected in service specifications.

13.4. The Panel identified the importance of ensuring that training on domestic violence and abuse addresses issues for specific communities of interest,

so that professionals are aware of whom this may affect and any unique needs or barriers to accessing help. This should include ensuring that introductory training on domestic abuse has information on these communities and, where appropriate, more advanced training is developed to further develop practice responses.

14. Need for improved collecting and sharing of information between professionals

14.1. The Panel identified issues with the recording and sharing of information disclosed to staff in this case: the importance of checking personal details when meeting a client, the recording of third party information (noting who provided the information recorded), disclosures of abuse, and the patient's responses and wishes (including the role of consent where a patient asks that 'nothing be done'), and the sharing of that information.

14.2. The Panel noted an overarching theme, reflected across a number of services, related to information-sharing and the confidence of professionals both to explore issues relating to disclosures made by Mr C and to share information. It was of note that, although Mr C was in contact with a range of professionals, there was little psychosocial information recorded that would have provided a context for his presenting problems and may have led to further questions.

Conclusions and recommendations from the review

15. Conclusions

15.1. In a coordinated community response (CCR), all parties are aware of domestic abuse and its dynamics. They know the indicators of abuse and the risk factors, their role in the coordinated effort, and act to help victims. The CCR closes the gaps between services. The professionals who dealt with Mr C each did their specific job, but without an understanding of their role in the coordinated response – in the care pathway to help – and without a broader understanding of health to include safety.

15.2. Mr C had been assaulted at least over a period of months and probably years. He was physically, emotionally and financially abused. His family knew of some of the abuse but were unable to convince Mr C to seek help or leave Mr Y. The many health professionals that Mr C saw in the last year of his life did not pick up the signs of abuse or ask about it. Mr C's problematic alcohol use appears to have been allowed to mask the signs of abuse, even when he disclosed.

15.3. It also may be that being an older gay man may have made it more difficult for Mr C to seek help and for professionals to identify the assault as domestic abuse.

15.4. When Mr C did disclose, the professionals did not honour that disclosure by responding pro-actively. They responded with a narrow set of options or discounted what he said and did not take pro-active steps to help him. They addressed his immediate health needs but did not prioritise his safety as required in Recommendation 8 of the *Nice Guidance: Domestic violence and abuse; how health services, social care and the organisations they work with can respond effectively.*

15.5. Mr C's [redacted] GP and the healthcare professionals involved with him during his February admission may have identified domestic abuse if they had asked. They all focused on the presenting health problems without asking questions about the wider context. We cannot tell if the 'falls' recorded over the last year of his life were the result of increasing poor health, increased problematic alcohol misuse, or assaults. Mr C may have not disclosed but a failure to ask means that he was not given the opportunity to get help.

15.6. Mr C did disclose, repeatedly, on the night of 14 May 2012 and no one responded to those disclosures. He was left with his abuser and, after 2 hours, left A&E without having seen the doctor and was killed several weeks later.

16. Recommendations

To improve health and social care responses to patients and employees

16.1. **Recommendation 1: Implement the NICE guidance on *Domestic violence and abuse: how health services, social care and the organisation they work with can respond effectively.***

16.2. **Recommendation 2: Review training for health care professionals on domestic violence and abuse and ensure it is available to all frontline staff.** (Training should include the following key messages:

- Health symptoms that correlate to domestic abuse.
- Dynamics and indicators of domestic abuse, especially how an abusive situation and an abuser may present to them in the course of their work. Highlight particular issues with older people, with carers, and with those who are LGBTQI.
    - How to undertake targeted and routine enquiry, and the appropriate responses to any disclosure of abuse or assault.
    - Indirect discrimination and the need for a pro-active response.
- Clarify that staff should respond to all victims, not just those who meet the vulnerable adult criteria: the care pathway for domestic abuse victims requires all professionals to act – to provide an emergency response when required (ambulance, A&E, police); to provide a statutory response (for vulnerable adults and children); and an empowering response for all: to listen, believe, ask what the victim wants and what they can do, record and share, and provide a specialist to talk about their situation and options)

16.3. **Recommendation 3: Primary Care Providers, and NHS England commissioners, support primary care providers and staff to respond to domestic violence and abuse by adopting Recommendation 16 of NICE Guidance and by commissioning the IRIS project locally.** (This

is in order to ensure that staff undertake targeted enquiry, and are supported by policies and procedures locally and that staff have access to a formal referral pathway to support a response to a disclosure).

16.4. **Recommendation 4: Secondary Care Providers, and local Health Commissioners, to support Secondary Care providers and staff to respond to domestic violence and abuse, specifically by ensuring that staff undertake targeted or routine enquiry as appropriate.** (Staff should be supported by local policies and procedures that include a formal referral pathway. They should be able to access advice when they require it either from specialist agencies or champions within their organisation).

16.5. **Recommendation 5: South East Coast Ambulance Service and the service's commissioners support a response to domestic violence and abuse, by ensuring that staff undertake targeted enquiry as appropriate.** (Staff should be supported by local policies and procedures that include a formal referral pathway. They should be able to access advice when they require it either from specialist agencies or champions within their organisation).

To improve the community's understanding and response

16.6. **Recommendation 6: Launch publicity and awareness-raising for family, friends and victims**

(To include:

- Information about where victims, family and friends can go for advice and to talk about their options and
- Tailored information for specific communities of interest, including gay men and their family and friends to name the abuse they are experiencing)

16.7. **Recommendation 7: Provide guidance and support for employers and unions to develop employment policies that address domestic abuse, ensuring that employees are asked about domestic abuse and supported to address this before instigating disciplinary actions.**

(Work could be prioritised with health providers so that their awareness of the link between mental health and substance misuse problems and domestic abuse when working with patients is reflected in their own employment practices).

To improve commissioned services' responses

16.8. **Recommendation 8: The specifications for all services commissioned locally include provisions in relation to domestic violence and abuse, reflecting the City wide VAWG outcomes.**

To improve the communication between agencies and services

16.9. **Recommendation 9: NHS England (Surrey and Sussex) and the local Clinical Commissioning Group to provide guidance and training for health professionals on recording and sharing information, particularly in regard to domestic violence and abuse.** (This case might be used to develop that guidance).

16.10. **Recommendation 10: The ambulance service should develop their response to patients who disclose domestic abuse and those cases where staff suspect there has been domestic abuse.** (A model has already been piloted for this and the pilot should be built on. Key areas for development are training for targeted enquiry, the role of consent, a full understanding of the care pathway for victims of abuse, recording of information and patient's wishes and sharing information with other agencies).

16.11. **Recommendation 11: Learning is disseminated from this review to ensure staff are aware of the importance of their responses to disclosures or concerns, the value of good communication with patients, and the need for information-sharing.** (The understanding gained through this exercise should be used to develop responses and processes from all healthcare agencies. Work could be prioritised with

Ambulance crews, A&E staff, GPs and Police using the review of this death as a case study).