SETDAB | Southend, Essex & Thurrock Domestic Abuse Board

Domestic Homicide Review
Executive Summary

Under s9 of the Domestic Violence, Crime and Victims Act 2004

Review into the death of Heidi
in December 2017

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August 2019

Braintree District Community Safety Partnership

Preface

The Braintree Community Safety Partnership wishes at the outset to express their deepest sympathy to Heidi's family and friends. This review has been undertaken in order that lessons can learned; we appreciate the support and challenge from families and friends throughout this difficult process.

We are also grateful to the family of James. Their engagement has helped us gain an insight into the difficulties he faced. Their desire to make a difference is acknowledged and their challenge is taken is a positive contribution to improve services.

This review has been undertaken in an open and constructive manner with all the agencies, both voluntary and statutory, engaging positively. This has ensured that we have been able to consider the circumstances of this murder in a meaningful way and address with candour the issues that it has raised.

The review was commissioned by Braintree Community Safety Partnership on receiving notification of the death of Heidi in circumstances which appeared to meet the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004.

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Section One – The Review Process

1.1 Introduction and agencies participating in the Review

1.1.1 This summary outlines the process undertaken by the Braintree County Community Safety Partnership Domestic Homicide Review Panel in reviewing the death of one of its residents. The death occurred in December 2017.

1.1.2 The victim in this case was Heidi, she was a 33-year-old woman who was killed by her partner, James, at the home they shared together. They had been in a relationship for several years. They had no children together, neither had children from any previous relationship. James had suffered from acute and severe mental ill-health since the age of 17.

1.1.3 This Review has taken place alongside a criminal investigation that resulted in a trial of facts being heard in January 2019 after it was agreed that James was incapable of standing trial due to his severe mental ill-health. That trial of facts established that he was responsible for Heidi's killing. He was subsequently committed to psychiatric care as a result of a Hospital Order, together with an accompanying Special Restrictions Order that is without time limit.

1.1.4 Alongside this Review there has also been two investigations by the Independent Office of Police Conduct (IOPC), a Serious Incident Review by the mental health trust who provided care to James, and an NHS England Independent Review of the mental health care provided to James.

1.1.5 As this Review was drawing to a conclusion HM Coroner made a decision to undertake an Article 2 Inquest with a jury. This is scheduled to take place in March 2020.

1.1.6 This Review has attempted to draw together the different inquiries to ensure that nothing is missed. Domestic Homicide Review Panel meetings have included representation from the IOPC[1] and NHS England and joint interviews have been held where possible. However, the different legal processes that support the IOPC regime and that of NHS England necessarily mean that those reports stand alone. This does not mean that the key recommendations that cross agencies have not been included, it means that specific clinical or practice-based health recommendations remain within the yet unpublished NHS England report.

1.1.7 As a result, this report concentrates upon the focus of DHRs, i.e. the relationship between the couple. It seeks to establish whether domestic abuse was a feature of that relationship and if it was, to find that trail of abuse. Moreover, it seeks to look at what can be learned and what changes can be made to better protect others in the future. It will not repeat specific single agency learning, in particular in relation to James' care as this will be covered in detailed by the NHS reviews. It will, though, look to make recommendations that are cross agency or where it is clear that a different approach may better protect others.

1.1.8 Braintree County Community Safety Partnership was notified by the death by Essex Constabulary two days after Heidi's death. Within one month, a meeting of the Southend,

[1] Independent Office for Police Conduct

Essex and Thurrock Domestic Abuse Core Group was held. It was decided that a Domestic Homicide Review would be undertaken, and the Home Office was notified of the decision on 17th January 2018. This demonstrates a timely response to the death.

1.1.9 An independent Chair and Report Author were appointed, and the Review Panel met for the first time on 2nd July 2018. There followed three further review panel meetings and individual meetings between the Chair of this Review, the IOPC and NHS England appointed investigators.

1.1.10 The final meeting of the Review Panel was in August 2019 to finalise the report and the findings therein, and consider the actions needed to address the recommendations.

1.1.11 It was not possible to complete the review within the six-month timescale set out in the statutory guidance due to the nature of the criminal proceedings in this case, the on-going IOPC investigations and the NHS Independent Investigation.

1.1.12 It was intended to include the NHS England Review within the body of this report. However, the legal process that surrounds it means that the timescales for the completion of that report remain unclear and thus this review is submitted with the acknowledgement that a detailed review of James' care will follow. It is his care that is the focus of the forthcoming inquest.

1.1.13 The following individuals and agencies contributed to the review:

- The family of Heidi
- The family of James
- Essex Police – Chronology and IMR
- Essex Partnership University (NHS) Foundation Trust (EPUT) – Chronology and IMR
- Victim's GP – Chronology and IMR
- Victim's employer – written response

1.1.14 Attempts were not made to engage with James for the purposes of this Review due to his on-going acute mental ill-health.

1.2 Purpose and Terms of Reference of the Review

1.2.1 According to the statutory guidance, the purpose of the Domestic Homicide Review is to:

- 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
- 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
- Apply these lessons to service responses including changes to policies and procedures as appropriate

- Prevent domestic violence and homicide and improve service responses to all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest possible opportunity
- Contribute to a better understanding of the nature of domestic violence and abuse
- Highlight good practice

1.2.2 The Review Panel agreed that the specific purpose of the Review is to:

- Establish the facts that led to the incident in December 2018 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family.

- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.

- Establish whether the agencies or inter agency responses were appropriate leading up to and at the time of the incident in December 2018; suggesting changes and/or identifying good practice where appropriate.

- Establish whether agencies have appropriate policies and procedures to respond to domestic abuse and to recommend any changes as a result of the review process.

1.2.3 The scope of the Review, as agreed by the Review Panel, is to:

- Draw up a chronology of the involvement of all agencies involved in the Heidi to determine where further information is necessary. Where this is the case, Individual Management Reviews will be required by relevant agencies defined in Section 9 of the Domestic Violence, Crime and Victims Act 2004 (revised 2016).

- Produce Independent Management Reviews (IMRs) for a time period commencing 1st January 2000 (thus covering the period of the couple's relationship and the onset of James' ill-health)

- Invite responses from any other relevant agencies, groups or individuals identified through the process of the review.

- Seek the involvement of family, employers, neighbours & friends to provide a robust analysis of the events.

- Produce a report which summarises the chronology of the events, including the actions of involved agencies, analyses and comments on the actions taken and makes any required recommendations regarding safeguarding of individuals where domestic abuse is a feature.

- Aim to produce the report within the timescales suggested by the Statutory Guidance subject to:
    - guidance from the police as to any sub-judice issues,

- sensitivity in relation to the concerns of the family, particularly in relation to parallel enquiries, the inquest process, and any other emerging issues.

Section Two – Agency contact and information learnt from the Review

2.1.1 Both Heidi and James had long-standing family ties to Essex. They had been living together for approximately ten years at the time of Heidi's death.

2.1.2 Heidi worked as a nursery nurse who undoubtedly worked well with the children in her care. She was described as always having a good bond with them all and she was a favourite to many. She was a valued member of the nursery team and described as being liked by everyone she worked with.

2.1.3 Heidi was described one of her friends as one of the kindest people she had met with a positive attitude.

2.1.4 Whilst James did not have a permanent job because of his ongoing health problems he managed to build up a small window cleaning round, which he worked at when his health allowed.

2.1.5 In April 2018 the couple moved to flat in North Essex, which they purchased with the help of James's parents. They both continued with their existing work and did not seek jobs in their new home town.

2.1.6 James was 36 years old at the time of the incident. He had experienced mental health problems since he was 17 years old and this was exacerbated by illicit drug use whilst at university. At the time of this incident, he had several diagnoses which include Paranoid Schizophrenia, Generalised Anxiety Disorder and Mental and Behavioural Disorders due to the use of alcohol, dependence syndrome and episodic use (Dipsomania).

2.1.7 In the weeks leading up to the incident James's health had deteriorated and he had sought further help from his GP and the mental health trust. The day before the incident James's called the police to report a burglary at his home. His report was confused, and he declined police attendance until he had 'sought legal advice'. Police had not attended the report before this tragic incident subsequently took place although they had made several telephone attempts to contact him. On the day of the incident itself James had been visited at home by staff from the mental health team who recognised his deteriorating state.

2.1.8 On the night of the incident, Heidi called James' parents who live in Spain. She was frightened of James' behaviour, although it remains unclear as to whether she was frightened of him harming himself, her or both of them. As a result, James' mother called the mental health team and the police. Police attendance took in excess of 2 ½ hours. When they arrived, they found Heidi deceased. The IOPC have reviewed the police's handling of the report of burglary made by James and the call for assistance made by his mother (and followed up by his father). Their reports have now been published.

2.1.9 Little was known by agencies, other than health colleagues, about the couple.

2.10 Evidence of domestic abuse

2.11 This review has considered whether there is evidence of any trail of abuse within this relationship prior to the events that led to Heidi's death. In addition to scrutiny of all agency involvement her family were asked directly if they thought James had ever been physically abusive towards her and they were adamant that he loved her and would not do anything to hurt her. There are no records of Heidi disclosing to anyone that James was violent towards her. Heidi's manager (who was also a close friend) also told the review that she never had any reason to believe that James was physically abusive towards her. She says that they never saw any signs of physical abuse.

2.12 There was no sense of Heidi hiding from her family and friends (some of whom were also work colleagues) the extent of James's illness. She was always open and honest about what he was going through and if he was having a difficult time.

2.13 Despite the information gathered by the police as part of their murder investigation, this Reviews conversations with witnesses, friends and family, and scrutiny of all the couple's interactions with organisations this review concludes that it cannot say with certainty whether domestic abuse had previously been a feature of this relationship. There are indications of troubling behaviour, but these are undoubtedly exacerbated by James mental ill-health (see section 3.5 of the main report). There are only two people who know what went on within that relationship. What we can say is that everyone who knew the couple described them as very much in love and that Heidi was very supportive of James's illness.

Section Three – Key issues arising from the Review

3.1 **James mental ill-health, its knowledge and impact upon services.**

3.2 The most overwhelming issue within this review is the level of impact of James' mental ill-health and the availability of information that would allow emergency services to form risk assessments based upon complete information.

3.3 The call from James's mother on the night of the incident was categorised as a 'concern for safety' and NOT as a domestic incident.

3.4 The police accept that errors were made in the handling of the call on the night in question. That call handling has been the subject of the IOPC investigation and their findings have been published separately. This Review does not seek to revisit those specific issues; however, it has worked alongside the IOPC to consider why those errors were made and whether awareness or lack of domestic abuse was a factor.

3.5 Having reviewed the available documents in this case, spoken to family, friends and other witnesses, we come to the conclusion that the call from James's mother appeared to centre around her concerns for her son's safety and wellbeing. The officer who took that call followed that line of conversation and asked about his state of mind, thoughts of self-harm etc. They were aware that James's mother had spoken with the mental health team and also that the call from Heidi to her had happened around an hour previously. The questions asked focussed upon James, none of the questions appeared to consider the risk to Heidi. Vitally, the fact that James's mother could not get any response from Heidi seems to have been missed. This seems to have been a tragic but genuine error.

3.6 Moreover, and perhaps more importantly, this review comes to the conclusion that under current arrangements the police are asked to make decisions about dispatch based upon wholly incomplete information. They had no access to records that may have helped them understand the deterioration in James condition and thus the danger that Heidi faced. A simple check of James' mental health team's record would have flagged up that this was a case that required an urgent attendance by either the police, or in fact the police together with an appropriately trained mental health practitioner to intervene. This is a situation that should not continue. This review comes to a very clear conclusion that a greater access to an individual's whole circumstances would enable a more considered and informed response and thus afford all a greater level of protection. This review does not advocate police having access to an individual's mental health record, however, it does recommend that mental health staff with access to mental health records should be cited in police control rooms to aid in decision making.

3.7 Specific recommendations relating to James's clinical care will follow in the NHS England Independent Investigation when published.

Section Four – Conclusions

4.1 This review has considered all of the information gathered together across a range of statutory and voluntary agencies, from employers, friends and family of both the victim and the perpetrator. There is no doubt that this victim (Heidi) loved and cared for her partner and did everything she could for him to help him cope with his illness.

4.2 It is also clear that this perpetrator suffered from severe mental illness. The fact that he is unfit to stand trial and may spend the rest of his life in a hospital setting is testament to that fact. There was no dispute between the prosecution and defence in this case about the level of his illness, nor that a hospital order was the correct form of conclusion to this case, nor, indeed, that he should be subject to a lifetime special restrictions order. There is rarely such a level of agreement. It must be noted however, that at times this perpetrator did not take his medication and did abuse alcohol and controlled drugs; these were choices he made.

4.3 Heidi was killed in what the Judge described as a 'frenzied and awful killing'. The fact that she called her partner's parents for help illustrates that those last few minutes of her life must have been mystifying and terrifying.

4.4 This review has sought to establish whether prior domestic abuse was a feature of the couple's relationship. There are indicators of behaviour which may have been indicative of control but equally they may have arisen from this perpetrator's level of illness, we are simply unable to say.

4.5 The police had no information about the level of illness from which James was suffering at the time his mother called them for help. Had they known that he was a person who may be descending into crisis it may well have resulted in a quicker despatch, or indeed a referral for immediate attendance by specialist mental health nurses, or both. This highlights a gap that continues to exist in our emergency response to people with serious mental health issues. It is the understandable advice given by mental health staff to carers that if they fear for their or their loved one's safety then they should call for emergency help, yet, the police are not afforded that information to allow them to properly risk assess for appropriate deployment. More needs to be done. The recommendations within this review are aimed at protecting others who may find themselves in similar circumstances.

4.6 This review, in common with others, demonstrates that the level of risk of harm to, or by, those with mental illness increases at the time of significant events in a person's life. In this case a house move also meant a change in the mental health team supporting the perpetrator. This must be recognised in care plans and crisis plans discussed fully with all those involved in that person's life.

4.7 This tragic loss of life has left two families devastated. Its ripples go far wider than those immediately involved. We hope that the lessons learned and the changes made as a result of this review are able to give them some comfort in that others will be better protected. Our thoughts are with both families.

Section Five – Recommendations

5.1 That a formal process should be developed by which the police can notify mental health professionals of an individual's deteriorating mental health where it does not meet the threshold for Section 135/136 of the Mental Health Act 1983 or the Mental Capacity Act 2005. The review reiterates the recommendation made in previous DHRs published in 2017

5.2 That Essex Police and EPUT consider basing a mental health practitioner in the force control room with access to mental health records. Had this been in place on the night of the incident, then the force control room would have been able to assess the concerns of James's parents alongside his mental health history.

5.3 That NHS England and CCGs remind primary care services to complete a transfer summary in the electronic medical records (regarding patients with mental issues) when a surgery becomes aware that a patient is moving to a new locality.

5.4 That all agencies are reminded of the significance of information sharing with primary care services (GPs) to ensure clarity of information and continuity of care. It would be helpful if GPs are made aware when patients do not attend (DNA) appointments with other services.

5.5 That NHS England and CCGs remind GPs to complete a mental capacity assessment when there appears to be a lack of capacity