Domestic Homicide Review (DHR)

Southend Community Safety Partnership

Executive Summary Report

“Martine” January 2019

Author’s Name

Tracy Hawkings B. Ed

Overview Report author

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SUMMARY OF CONTENTS

1.0 REVIEW PROCESS

1.1. This summary outlines the process undertaken by Southend Community Safety Partnership (SCSP) Domestic Homicide Review Panel in reviewing the homicide of Martine, a resident in their area.

1.2. The following pseudonyms have been used in this review for the victim and perpetrator and other parties to protect their identities.

- Martine – Female who was murdered (Aged 40. Ethnicity: White European).
- Adult B – Male partner of Martine and person responsible. (Aged 32. Ethnicity: White European).
- Adult C – Mother of Martine.
- Adult D – Previous partner of Martine.

1.3. Adult B pleaded guilty to the murder of Martine at Basildon Crown Court in July 2019. He was sentenced to life imprisonment to serve a minimum term of 26 years. He did not appeal the sentence.

1.4. The process began with an initial meeting of the Southend, Essex and Thurrock Domestic Homicide Review Core Group on 21st February 2019 when the decision to hold a domestic homicide review was agreed.

1.5. Nine of the sixty agencies contacted confirmed contact with the victim and/or perpetrator and were asked to secure their files.

2.0 CONTRIBUTORS

2.1. The agencies who have contributed to this DHR are:

- ◊ Southend Clinical Commissioning Group – Queensway Surgery (SCCG - IMR)
- ◊ Essex Partnership University NHS Foundation Trust (EPUT- IMR)
- ◊ Southend University Hospital NHS Foundation Trust (SUHFT- IMR)
- ◊ East of England Ambulance Service (IMR)
- ◊ Essex Police (Report)
- ◊ Southend Borough Council Adult Social Care (Report)
- ◊ Southend Borough Council Children's Social Care (Report)
- ◊ Essex Probation Service (Report)
- ◊ South Essex Homes (Report)

2.2. In June 2019, the DHR Chair wrote a number of letters to the family and two close friends of Martine. The DHR Chair also wrote to Adult B and his mother and sister. All parties were

provided with a copy of the Home Office DHR leaflet entitled Domestic Homicide Information Leaflet for Family Members.

2.3. The DHR Chair had two meetings with the mother and sister of Martine and spoke to her mother on the telephone on other occasions.

2.4. In December 2019, Adult B contacted the Independent Chair to confirm he was willing to take part in the review. A visit was arranged and took place on 30th January 2020.

2.5. Independence and Impartiality are fundamental principles of delivering Domestic Homicide Reviews and the impartiality of the Independent Chair and Report Author and panel members is essential in delivering a process and report that is legitimate and credible. None of the IMR authors or panel members, had direct involvement in the case, or had line management responsibility for any of those involved.

3.0 REVIEW PANEL

3.1. The panel for this review was made up of the following representatives;

- ◊ Tracy Hawkings – Independent Chair and Report Author.
- ◊ Imelda Callowhill – Lead Nurse, Safeguarding Adults – Southend Clinical Commissioning Group.
- ◊ Tendayi Musundire – Head of Safeguarding – Essex Partnership University NHS Foundation Trust.
- ◊ Paul Hodson – Associate Director for Safeguarding Services – Southend University Hospital NHS Foundation Trust (SUHFT).
- ◊ Helen Brown – Inspector – Public Protection Unit – Essex Police.
- ◊ Lynn Scott – Head of Southend Adult Social Care
- ◊ Sarah Conlon – Service Manager – Safe Steps, Southend Domestic Abuse Service.
- ◊ Paul Hill – Southend Safeguarding Adults Board Manager.
- ◊ Simon Ford – Head of Community Safety – Southend Borough Council.
- ◊ Michelle Williams – Domestic Abuse Co-ordinator – SETDAB.
- ◊ Jacob Nurdan – Domestic Abuse Support Officer – SETDAB.

3.2. None of the panel members or IMR writers knew the individuals involved, had direct involvement in the case, or had line management responsibility for any of those involved.

3.3. The panel met on four occasions. In addition, contact was made with panel members on a regular basis to clarify issues and matters of accuracy about their agency's involvement with the family.

4.0 AUTHOR OF THE REPORT

4.1. The Southend, Essex and Thurrock Domestic Abuse Board appointed Tracy Hawkings as the DHR Chair and Overview Report Author on 28th May 2019.

4.2. Tracy is a safeguarding consultant specialising in undertaking reviews (Critical Incidents, Serious Case Reviews, Domestic Homicide Reviews and Post Case Reviews). Tracy previously served as an officer with Essex Police and has 30 years policing experience. During her service, Tracy was head of the Crime and Public Protection Command, working extensively with partner agencies at a strategic level, including those working to deliver policy and practice in relation to domestic abuse. Tracy was previously, Head of Major Crime and an accredited Senior Investigating Officer responsible for leading homicide investigations including domestic homicides.

4.3. Tracy retired from the Police service in March 2017 but has spent the intervening working in the field of Public Protection for Suffolk, Hertfordshire and the National Safeguarding Team for the Church of England. She has not had any direct involvement with Southend agencies nor with the policies, practices or operational oversight of the resources deployed in this case since her retirement.

5.0 TERMS OF REFERENCE

Statutory Guidance (Section 2.7) states the purpose of the Review is to:

5.1. Establish what lessons are to be learned from the domestic homicide involving Martine and Adult B regarding the way in which local professionals and organisations worked individually and together to safeguard victims;

5.2. 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;

5.3. Apply these lessons to service responses including changes to policies and procedures as appropriate; and

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

5.5. Contribute to a better understanding of the nature of domestic violence and abuse and highlight good practice.

Specific terms of reference set for this review

5.6. To provide an Overview Report which articulates the life of the victim through her eyes; to understand her reality in her dealings with those around her including professionals.

5.7. To identify the history of the victim and perpetrator and provide a detailed chronology of relevant agency contact with them. The time period to be examined in detail is the date the couple are

believed to have started their relationship (April 2018) and the date of the victim's homicide in January, 2019.

5.8. Agencies with knowledge of either the victim and/or perpetrator which falls outside of that timescale are to provide a brief summary of that involvement.

5.9. To examine whether there were signs or behaviours exhibited by either the victim or alleged perpetrator in their contact with services which could have indicated the level of risk.

5.10. Agencies reporting involvement with the victim and/or the perpetrator to assess whether the services provided offered appropriate interventions, risk assessments, care plans and resources. Assessment should include analysis of any organisational and/or frontline practice level factors which impacted upon service delivery.

5.11. What learning if any is there to be identified in the management of either party. Is there any good or poor practice relating to this case that the Review should learn from? Each agency is asked to examine best practice in their specialist area and determine whether there are any changes to systems or ways of operating that can reduce the risk of a similar fatal incident taking place in future?

5.12. The following are key issues which will be explored further with the relevant agencies in the review:

Martine's history of mental ill-health and dependency on drugs and alcohol.

Adult B's history of alcohol and/or drugs dependency.

Martine's history of domestic abuse with previous partners.

Martine's attendance at Queensway Centre and Taylor Centre in the weeks prior to her death where concerns were raised connected to her relationship with Adult B.

Martine's attendance at Southend General Hospital on 6th December 2018, following an overdose of prescribed drugs, alcohol and cocaine. Martine reported a contributing factor to be an altercation with her boyfriend, Adult B.

6.0 SUMMARY CHRONOLOGY

6.1. Martine was born in 1978. From the age of two, she was brought up by her maternal grandparents, although she had regular contact with her mother. When Martine was in her late teens, she became estranged from her family.

6.2. In 1998, when aged 21 years old, Martine gave birth to her only child. She separated from her partner soon afterwards, and they went on to share joint custody of their child.

6.3. Between 2000-2010, Martine had other relationships and there are three police reports of domestic abuse incidents involving Martine and two previous partners.

6.4. In 2010, Martine had a long-term relationship with Adult D, the person, who was described by her family as the love of her life. Tragically, Adult D was diagnosed with terminal cancer in 2017 and died from sepsis following a dog bite. The incident with the dog, was witnessed by Martine who was traumatised by the event and subsequently devastated by his death. There were reported suicide attempts following his death.

6.5. Martine met Adult B in March 2018 through a mutual friend. Their relationship developed quickly, and it was not long before Adult B moved into Martine's flat with her. The flat was rented from the local Housing Association[1].

6.6. There is little information held by any of the agencies involved with regards to the dynamics of the relationship between Martine and Adult B. Similarly, during this period of time, Martine was estranged from her family and they were unable to provide any information in relation to Martine's contact with professionals.

6.7. Martine had a number of diagnosed medical conditions which included fibromyalgia, asthma, depression, bipolar disorder and emotional unstable personality disorder (EUPD). She was prescribed medication for her conditions which included a combination of painkillers, sleeping pills, anti-psychotic drugs and drugs for anxiety[2]. Some of the prescription drugs were prescribed by the GP and others by her consultant psychiatrist at Essex Partnership University Foundation Trust (EPUT).

6.8. At 0542 hours on 6th August 2018, Adult B was conveyed to hospital by ambulance having presented with a query seizure. He denied taking any recreational drugs but admitted to taking 400mg of tramadol for his painful knee. History given by Adult B to paramedics was that he was having sex with his girlfriend, after which he went downstairs to go to the toilet and thinks he had a seizure. He referred to his 'wife' also having a seizure shortly after he had his. He felt fine at time of medical review in the emergency department. He was discharged with GP to refer him to the neurology clinic.

6.9. At 0550hrs on 6th August 2018, Martine was conveyed by ambulance to the Emergency Department at Southend hospital following a seizure. The seizure was witnessed by the Ambulance Crew whilst they were attending her partner, Adult B. Martine denied any drug abuse. She described being well prior to the seizure. She sustained a cut to head during the seizure. The attending doctors queried substance use. She was discharged and referred to her GP for follow up. During the assessment process, Adult B was referred to as Martine's main carer.

[1] Source Interview with Adult B – 30th January 2020 – Woodhill Prison para 4.6 to 4.11 DHR Report.
[2] The medication prescribed was tramadol, zopiclone, omeprazole, propranolol and pregabalin.

6.10. At 1149 hrs the same day, Martine re-attended the emergency department following two witnessed generalised seizures within the past 24 hours. The first seizure (described above) occurred after calling an ambulance because her partner was having a seizure. The 2nd seizure and subsequent admission occurred whilst Martine was being driven home by a neighbour. Martine denied excess alcohol intake. There was mention in the notes that the secondary seizure occurred due to the effects of a combination of alcohol and rat poison. Martine stated they had rat poison in the house due to an infestation of mice. Systemically she was well and her blood tests results were unremarkable. A spine and head CT scan showed no abnormality. The only recent change noted was the commencement of Martine on the drug fluoxetine. There was no acute kidney injury or sepsis. The first seizure occurred whilst ambulance crew were attending the property to see Adult B. Martine was transferred from the emergency department to a ward at 1600hrs on 6th August 2018. She was fully mobile but complaining of tiredness.

6.11. Martine had a neurology assessment on the ward which showed normal neurological functions. She denied taking rat poison. She had a small head wound as a result of a fall (witnessed). Martine was referred for further neurological review as an outpatient. Seizure safety advice was given. Martine was discharged from the ward on 7th August. A follow up appointment was arranged with Neurology and an EEG[3] as an outpatient which was completed as showed nothing abnormal. A letter was sent by SUFHT to Martine's GP practice.

6.12. At 1602 hrs on 8th August 2018, Martine attended the A&E department in company with her partner, Adult B. Martine gave a history of Adult B suddenly going stiff with up-rolling of his eyes lasting 2-3 minutes. He had a second episode about 2 hours later which was similar in presentation. He gave a past history which included cannabis (marijuana) use and a history of deaths in his family of brain tumours. The medical team noted, he had also attended on 6th August 2018 and they referred him to the medical team, but he discharged himself without being seen by them.

6.13. Two weeks later on August 21st, 2018, Martine was seen by the GP for a medication review. This was initiated following notification from SHUFT of the seizures on 6th August. The discharge letter to her GP stated that "the patient had had a seizure after calling the ambulance because her partner (Adult B) had also had a seizure". Martine had reported to the A&E Doctors, that she had recently re-commenced on fluoxetine[4]. All tests were normal therefore she was discharged.

[3] An electroencephalogram (EEG) is a test used to find problems related to electrical activity of the brain. An EEG tracks and records brain wave patterns.

[4] Fluoxetine is also known as Prozac and is an anti-depressant.

6.14. The GP recorded that Martine had no suicidal thoughts, maintained a good rapport and eye contact throughout the consultation. She was prescribed her medication and the GP sent a referral to the psychologist the next day.

6.15. On 13th September 2018 there was contact with the GP where Martine stated she had been better in herself with no suicidal thoughts. She reported she was generally better motivated and responding well to fluoxetine.

6.16. On 18th September 2018 Martine was seen by a GP for a repeat tramadol prescription, and on the 1st October 2018, 14 days later, there was a repeat prescription recorded on the electronic record for sleeping tablets, pain killers and anti-psychotic medication completed by her GP[5].

6.17. On 18th October 2018 Martine attended the Queensway surgery for a routine health check and to have a Full Blood Check (FBC), urea and mineral (Electrolytes) and liver function tests.

6.18. On 6th December 2018, a GP contacted Martine by telephone following a concern raised with the surgery by a local pharmacy. The entry reads that concerns had been raised with the pharmacy by the boyfriend of Martine that she wanted to take all her medications at once. Martine informed the GP that she felt her mental health was stable and she was under the care of a mental health team and had an appointment in two weeks' time. Martine reassured the GP, she did not feel suicidal and thought the concern may have been raised by her boyfriend because they had argued. She informed the GP, she would contact them immediately to "report any change in her condition".

6.19. At 1848 hrs on 6th December 2018, Martine contacted the ambulance service reporting she had taken an overdose of tramadol and cocaine. During the call, a male (presumed Adult B) spoke to the call taker and informed them Martine was fine and did not require an ambulance. It was noted he tried to influence the ambulance service not to attend but this information was not passed on to the attending crew. A crew attended and conveyed Martine to the emergency department. Martine reported, she had had an argument with her partner and then took cocaine with 2 bottles of wine around 11am. Martine then took an overdose of tramadol, 300mgs in total. Patient was assessed on the Acute Medical Unit and left in for observations and to be assessed by the Rapid Assessment Interface and Discharge Team (RAID).

6.20. On the 7th December 2018, Martine was assessed by the Rapid Assessment Interface and Discharge Team. (RAID)[6]. She had overdosed on her tramadol tablets having taken ten 200mg

[5] Medication prescribed was zopiclone, tramadol, and aripiprazole.

[6] RAID Team provides an in-reach psychiatric liaison service to prevent avoidable admissions to inpatient wards and mitigate longer lengths of stay associated with mental illness as a co-morbidity to physical conditions.

tablets and one 100mg tablet. Martine reported to the team that the trigger factor for the overdose was that she had lied to her boyfriend, about something she had done but would not discuss it further with the assessing nurse. According to Martine, Adult B had had found out about the lie and they had separated the previous night. Martine disclosed to the RAID team that her deceased husband had been violent towards her in the past but not her current partner, referring to Adult B. There had been two previous suicide attempts following the death of her husband. She denied any suicidal intentions on this occasion and indicated she wanted to return home. There was no disclosure of any risk from Adult B.

6.21. Martine disclosed that in response to Adult B leaving after the argument, she drank two bottles of wine and took cocaine, which she felt was out of character for her. She stated she would not have taken the overdose if it were not for the fact she was under the influence of alcohol and the illegal substance. The notes record, she had a history of overdoses following relationship breakups and this remains a trigger and risk factor for her. She also disclosed the second anniversary of the death of her previous partner was coming up in January 2019 and this would be a difficult time for her, albeit she felt she could cope. She also disclosed she was in debt and intended to seek the assistance of the Citizens Advice Bureau.

6.22. She stated that she took an overdose on the 6th December 2018 as she felt in a destructive mode at the time. She reassured the RAID team, she did not want to die and had lots of plans for the future. At the time of the overdose, she was worried that she would not be in a relationship with her partner, but this turned out not to be case, as they had since reconciled.

6.23. Adult B was present for part of the assessment. He was reported as being supportive but also tearful disclosing he struggled to understand Martine's condition of EUPD. As part of the release plan, he agreed to attend an EUPD course with Martine to increase his understanding of her condition.

6.24. The assessment stated: - "Martine is a 40-year-old female with a history of contact with mental health services. Has current diagnosis of EUPD and historical diagnosis of bipolar affective disorder. She has a history of overdoses following relationship break ups and this remains a trigger and risk factor for her. The medical release plan detailed the following:

- ◊ Martine was fit for discharge
- ◊ She was to attend an outpatient's appointment on the 14th December 2018 with her psychiatrist.

- ◊ Contact number for CRUSE[7] given for there had been a discussion about bereavement and Martine felt bereavement counselling may be of use.
- ◊ They discussed attending the recovery college but Martine did not want to engage with this.
- ◊ Martine and Adult B plan to attend EUPD course provided by Southend Area Voluntary Sector.
- ◊ Martine agreed to make contact with her mental health team if she had any suicidal feelings. She was also provided with the crisis line and Samaritans number.

6.25. On 7th December 2018 Southend University Hospital NHS Foundation Trust, A&E department communicated by letter to Martine's GP advising that Martine had attended on the 6th December following an overdose of alcohol and medication pills. The letter gave detail in relation to her assessment and the fact she was admitted overnight and assessed by the hospital psychiatrist.

6.26. On 10th December 2018 Martine and Adult B attended the surgery together and were seen by a GP. During the consultation, Martine reported she had lost her medications and wanted another prescription for zopiclone which is a sleeping pill. There appears to have been no consideration given to the fact, she had taken an overdose only four days before. She also stated that she wanted to discontinue with tramadol which she had been taking for 15 years. The GP record states that Martine's mood was stable; she had no suicidal ideation and appeared calm. There does not appear to have been any in depth exploration by the GP in relation to the reason(s) for the overdose which involved Martine taking excessive tramadol in combination with alcohol and other substances.

6.27. On 14th December 2018, Martine attended an outpatient's appointment with her psychiatrist. During the appointment the incident on 6th December was discussed and the psychiatrist recorded that Martine stated, "all is well and that the argument has made the relationship stronger". The notes recorded the fact that Martine and Adult B were planning to attend an EUPD course provided by the Southend Association Voluntary Sector (SAVS). There is a letter on Martine's GP record advising that she was seen at the outpatient psychiatric clinic on 14th December 2018 and she was to continue with prescribed medications but to stop taking her anti-psychotic medication[8]. Martine was seen that day at the surgery by the practice nurse. She presented with cold symptoms, breathing problems, and was taking asthma medications.

[7] CRUSE – Charity set up to support bereaved people in England, Wales and Northern Ireland.
[8] The anti-psychotic medication was apriprazole.

6.28. On 19th December 2018, Martine was seen by a GP, she was requesting to be weaned off tramadol, stop dihydrocodeine and to have pregabalin[9] 50mg to control her fibromyalgia.

6.29. The following day on December 20th, 2018, Martine had a telephone conversation with a GP. The GP had contacted her after reading the letter from the hospital notifying them that Martine had taken an overdose of tramadol 2 weeks before (6th December), was taken into hospital and seen by the mental health team, and a psychiatrist. Martine advised that she now regretted her action, and that she had done this following a "tiff with her partner". She stated that Adult B mentioned he was leaving her and that this caused the acute reaction. She reassured the GP, that she now had no intention of taking her own life. The GP requested she attend the Queensway surgery for an appointment in two weeks' time or sooner if she had any thoughts of suicide or self-harm.

6.30. 11 days later on December 31st, 2018, Martine attended the Queensway Surgery and was seen by a GP. She requested an increase in dosage of pregabalin. She stated her mood had improved and she was less anxious and not feeling suicidal. Martine did not attend the follow up appointment with her GP arranged for January 2nd, 2019.

6.31. On January 7th, 2019, there was a telephone consultation between a GP and Martine recorded on the electronic record. Martine reported that she has lost her medications and required more pregabalin; therefore, a repeat prescription was provided.

6.32. The following day on January 8th, 2019 Martine requested additional propranolol[10] 40mg which is recorded on the record as having been prescribed.

6.33. On January 11th, 2019, Martine had a telephone conversation with a GP at the surgery where she expressed concern that her medications were now being prescribed on a weekly rather than monthly basis and the fact, she had not received any communication as to the reasons why. She reported she had stopped taking tramadol for her fibromyalgia which had been diagnosed 15 years ago; and that the multiple painkillers she was on, were having no effect. She stated the pain from her fibromyalgia was not helped by taking 75mg pregabalin twice daily, and she wanted to see if increasing the dose might be helpful. The record states that her mood has been low since she lost her partner following a dog bite and sepsis 2 years before. She has been affected by anxiety and low mood and was currently under the mental health team with 6 monthly reviews. The notes record "She feels the tramadol overdose was a one off and does not feel suicidal".

6.34. In response, the GP apologised to Martine for any miscommunication regarding the weekly scripts and, explained that this had been put in place following the letter from the mental health team

[9] Pregabalin is a drug prescribed to treat anxiety and epilepsy.

[10] Propranolol is a drug prescribed to treat anxiety and migraines.

giving detail of her overdose on 6th December, (letter dated 12th of December 2018). The GP explained this action was routinely put in place to ensure patient safety and was not personally directed at one person. The record shows that Martine understood why this was the safe thing to do and was happy now that the explanation had been clarified. Martine expressed a wish for the GP to consider issuing 28-day scripts as before, as she felt it would be possible to control her medication intake. She reported her current partner helped with her medication, and she was tolerating medication well with no reported side effects. The GP agreed to review the situation in 4 weeks and advised her to report immediately if there was any deterioration in her mental health. This is the last contact that Martine had with her GP and the surgery prior to her homicide.

6.35. During the afternoon and early evening of the fatal shooting (January 2019), Martine exchanged a number of "What's app" messages with a friend. The texts reveal, that Martine was deeply unhappy and struggling to cope with the death of her previous partner. She wrote she was currently experiencing difficulties in her relationship with Adult B. The couple had recently split up, but Adult B had agreed to come back for a month's trial. It appears as though she was struggling with an addiction to alcohol and drugs which may have been an indicator of domestic abuse and a way of coping with it. The texts from Martine also detailed that Adult B was "out of his head on whisky and tramadol" consumed during the morning of 13th January 2019 and had left the house following an argument[11].

6.36. At 19.12hrs the same day, Martine made a 999 call to Police and reported a domestic abuse incident between herself and her boyfriend, Adult B.

6.37. The duration of the 999 call was 37 seconds, during which Martine reported that her boyfriend was in her house and was refusing to leave. She stated he was being quite aggressive (in what form this aggression was manifesting is not explained). Martine then informed the call taker that her boyfriend was leaving and requested that the police units were cancelled.

6.38. At 19.18hrs, the Ambulance service received a call from Adult B reporting he had shot Martine and himself.

6.39. Police and paramedics attended the home address of Martine and found her with serious shot gun injuries to her face. She was conveyed to Southend hospital and subsequently transferred to the Royal London hospital where she died of her injuries two days later.

6.40. Adult B had also sustained minor facial shot gun injuries. He was conveyed to Basildon hospital. He was arrested at the scene and a sawn-off shot gun was recovered by Police. He admitted to the attending officer that he had shot Martine. He appeared unsteady on his feet and admitted

[11] Information provided by Review Officer for Essex Police – Report dated 24th July 2019.

to drinking an excessive amount of alcohol and to taking cocaine and other drugs. He did not provide an account during his police interviews. He was subsequently charged with the murder of Martine.

6.41. During the police investigation, police made further enquiries into the firearm found at the scene (a 12-gauge side by side hammer shotgun of Belgian origin). There was no direct match for the weapon on the National Firearms Licensing Management System and the weapon was not linked to any other criminality. Neither Martine nor Adult B held a firearms licence nor were any weapons ever registered to the address by any other party. The history of the weapon cannot therefore be established and would have been illegally held.

6.42. A forensic post mortem examination was performed on Martine. The cause of death was given as 'shotgun wound to the face'. There were also recent and healing injuries present which were not typical of assault or restraint immediately prior to death. Martine had sustained a fracture to her hyoid bone which could be consistent with strangulation or caused as a result of the shotgun injuries. The pathologist was unable to determine which was the cause of this.

6.43. Adult B pleaded guilty to murder at Basildon Crown Court in July 2019. He was sentenced to a minimum term of 26 years imprisonment. He did not appeal the sentence.

Information provided by Adult B

6.44. As part of the DHR, the Report Author visited Adult B in prison and had a meeting with him. The meeting was arranged at his request following receipt of a letter sent by the DHR Chair on 2nd June 2019. The information detailed in paragraphs 6.45-50. were provided by the perpetrator and given from his perspective.

6.45. Prior to meeting Martine, Adult B admitted to being a frequent user of cocaine and marijuana. He described Martine as having an addiction to cocaine and some of her prescription drugs particularly zopiclone and tramadol.

6.46. Adult B stated he suffered with moderate learning difficulties and for this reason never gained full time employment. He did a number of casual jobs for cash in hand. He stated, before meeting Martine he either lived at home with his mother or sofa surfed with casual acquaintances. He described himself as a bit of a loner.

6.47. Adult B stated that he and Martine were both frequent users of cocaine, which they used to take in combination with alcohol and Martine's prescribed drugs. He admitted to frequently taking Martine's prescription drugs, particularly tramadol. He said, the system made it very easy for them to access larger amounts of prescription drugs than she had been prescribed. He said Martine would frequently report lost medication to her GP or pharmacist and would always be prescribed with more, without any real challenge. They would also increase the prescription

drugs available to them by ordering them from the internet. He admitted to having a dependency on tramadol and believed this was the cause of the seizures that both of them suffered in August 2018.

6.48. Adult B said he has very little recollection of the day of the shooting. He had taken cocaine the day before and on the day itself, and was heavily under the influence of alcohol and tramadol. He stated he had argued with Martine but he could not remember what about. He could offer no explanation as to his actions. He admitted that the firearm used in the incident belonged to him and that it had been in the flat for some time. He could not remember making the 999 call to the ambulance service or being aware Martine had made a 999 call to the police just minutes before.

6.49. Adult B spoke about the effects of legal and illegal drugs and believed they had been a contributory factor which influenced his behaviour.

6.50. It is known from information from professionals that following her overdose on 6th December, Martine reported the loss of prescriptions on two occasions. She also attended the GP surgery to ask for increased dosage of her prescribed medication. It is not known whether or not she did this under duress and at the instigation of Adult B, but there does appear to be an escalation in contact with the GP surgery following her overdose and in the days before her murder. Certainly on the basis of information provided by Adult B, it is now known he was a frequent user of medication prescribed to Martine and had an addiction to tramadol.

7.0 KEY ISSUES

7.1. The review identified a number of areas where operational practice could be improved, and these have been addressed in the recommendations that have been made. These changes will enhance current operational delivery and ensure that victims and their families receive the highest standards of care and support.

7.2. There are four key areas of concern that the review has identified. Firstly, both Martine and Adult B were taken to hospital on 6th August following reports of "spontaneous" seizures. Adult B re-attended on 8th August following further seizures. They were both provided with adequate clinical care; however, perhaps further time could have been spent by professionals enquiring into the causes of this unusual event.

7.3. Secondly, when Martine was admitted to hospital on 6th December 2018, following her overdose, she disclosed the reason she took the action she did was because of an argument she had with her partner. Again, although adequate clinical care was given and an appropriate referral made to the RAID team, more time should have been spent with those entrusted with her care being

professionally curious and exploring the dynamics of the relationship between Martine and Adult B. Adult B was present for part of the RAID team assessment and articulated to the medical practitioners, he struggled to understand and cope with Martine's mental health condition. There was good communication from both the hospital and mental health services with the GP practice, but none of the professionals involved explored in any detail, the dynamics of the relationship or the risk factors involved.

7.4. The third aspect is the prescribing of additional medication following the reported overdose of Martine on 6th December. On the 10th December, she attended the surgery together with Adult B and said she had lost her prescription drugs and wanted a further prescription for zopiclone (A sleeping pill). On 7th January 2019, she contacted the GP surgery reporting she had lost her prescription and was subsequently prescribed additional pregabalin (used to treat her anxiety). On 8th January 2019, she telephoned the surgery and requested additional propranolol (used to treat anxiety) which was also prescribed. This is an area of concern that a patient who has recently taken an overdose can be prescribed further medication by medical practitioners, especially in the wake of a recent suicide attempt following a domestic argument.

7.5. The fourth area of concern is the long term prescribing of tramadol to Martine and how this drug may have impacted on both Martine and Adult B. There were three significant events in the months leading up to the incident which involved the taking of tramadol by one or both parties. Firstly, the incident on 6th August and following days, where both Martine and Adult B were admitted to hospital after experiencing seizures as a result of taking tramadol. Secondly, Martine took an overdose of tramadol, alcohol and cocaine on 6th December 2018. Thirdly, on the day of the incident, Adult B admitted to being heavily under the influence of alcohol, tramadol and other illegal drugs in his interview with the Report Author.

7.6. The panel were so concerned by the potential effects of tramadol, they sought the advice of an expert on medicines. In this case, the Panel consulted the Head of Medicines for Castlepoint, Rochford and Southend CCG's. The expert advised that there had been a 2019 National review by Public Health England on this issue and a programme of work was already underway to address recommendations within the report. The panel were reassured by this.

8.0 CONCLUSION

8.1. This is a tragic case where Martine lost her life in the most horrific and tragic of circumstances at the hands of Adult B. Adult B pleaded guilty to her homicide and is currently serving life imprisonment with a recommendation, he is not considered eligible for parole for 26 years.

8.2. Due to the fact Martine had been estranged from her family for many years prior to her death, her voice is not represented as well as the Review Panel would have liked. Martine did have contact with professionals both during the period under review and historically. This was linked to her diagnosed mental health conditions and problems with her physical health. There was a recorded history of domestic abuse with previous partners, and a history of previous suicide attempts. In the last nine months of her life, she entered into a relationship with Adult B. There is little information known about the dynamics of the short relationship between Martine and Adult B which led to her homicide in January 2019.

8.3. With regards to Adult B, little is known about his life due to the fact he had little contact with professionals and his family, perhaps the people, who know him best, have chosen not to engage with either the police investigation or this review. Adult B did agree to meet with the review author but advised he was unable to provide a great deal of information about the last month he spent with Martine due to the effects of alcohol and drugs which seem to be a factor in this case.

8.4. The Review Panel considered four factors which may have contributed to what happened. The fact remains, the only person who knows what happened has stated he has no recollection of the events of that day.

1. Adult B's dependency on a combination of alcohol and legal and illegal drugs significantly affected his behaviour.
2. There appears to have been an escalation in the taking of illicit substances in the days preceding the murder which is supported by the frequent reports of lost prescriptions.
3. Adult B could not cope with Martine's grief over the loss of an ex-partner. The timing of the murder coincided with the upcoming second anniversary of his death.
4. Adult B did display signs of controlling and coercive behaviour towards Martine.

9.0 LESSONS LEARNT

Learning Point One - Understanding of coercive control

9.1. The DHR Panel considered the current training provision within the organisations which feature in this report around the subject of domestic abuse. All IMR authors recorded detail of training provision and it is clear that all agencies take this subject seriously and regular training is provided. The DHR Panel are concerned, however, that there may be a lack of understanding of the signs and symptoms associated with coercive control within the definition of domestic abuse.

9.2. The definition of domestic abuse is "Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members, regardless of gender or sexuality. This can

encompass, but is not limited to, the following types of abuse: psychological, physical, sexual, financial and emotional." Coercive and controlling behaviour is defined as “Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour”.

9.3. Certainly, in this case, there were signs that Martine, was subject of coercive controlling behaviour exhibited by Adult B. The Review Panel was concerned that practitioners did not pick up on the significance of some of the things they were aware of. This is despite the established evidence base in relation to health care that identifies the wide range of presenting problems or conditions that are associated with domestic abuse.

These can be summarised as follows:

- ◊ Martine and Adult B were admitted to hospital between the 6th and 8th August 2018 with simultaneous seizures. It was clear from information provided by one of both of them that alcohol and drugs were a factor.
- ◊ There is mention in the notes following presentation at hospital on 6th August 2018 that rat poison may possibly have been taken by Martine. The reason given for it being in the property was because of an infestation of mice – this may have given some indication of poor living conditions.
- ◊ Adult B admitted to taking tramadol, (not prescribed to him), and had a history of cannabis (marijuana) abuse, both of which can have adverse effects on individuals especially when combined with alcohol.
- ◊ Martine took an overdose on 6th December 2018 following an argument with Adult B which caused him to tell her, he was leaving. Martine admitted to taking a cocktail of alcohol and prescription and illegal drugs.
- ◊ Adult B tried to cancel the ambulance, when called by Martine, to the report of her overdose on 6th December. This could be an indicator of controlling behaviour.
- ◊ Adult B was allowed to be present when medical practitioners were treating Martine following her overdose and during her consultation with practitioners from the Mental Health Team the following day. This could be an indicator of controlling behaviour.
- ◊ Martine during her assessment with the RAID team disclosed she was in debt and would seek advice from the Citizens Advice Bureau on debt management.

- ◊ Adult B was present at Martine's GP appointment on 10th December 2018 following her overdose. This could be an indicator of controlling behaviour.
- ◊ Martine disclosed to her GP during a consultation on 11th January 2019 that Adult B assisted her with her medication intake – this may have been an indicator of his control.
- ◊ Martine had a history of suicide attempts linked to her personal life.

  There is a link between mental health problems and domestic abuse. Mental health problems are a common consequence of domestic abuse and can render someone more vulnerable to abuse.
- ◊ The reports of loss of prescriptions shortly after taking an overdose. This could be an indicator of control if influenced by Adult B.
- ◊ A hidden risk, not known to professionals, was the fact Adult B kept an illegal firearm in the home which he admitted belonged to him. This could be an indicator of controlling behaviour and intimidation.

9.4. A summary produced by NICE identified the following indicators including associated with domestic abuse:

- ◊ symptoms of depression, anxiety, post-traumatic stress disorder, sleep disorders.
- ◊ suicidal tendencies or self-harming.
- ◊ alcohol or other substance use.
- ◊ Intrusive 'other person' in consultations including partner or husband, parent, grandparent.

9.5. The above is not the definitive list outlined in the guidance, but the relevant ones which have been identified during the review, as impacting on Martine.

Learning Point Two – Lack of Professional Curiosity

9.6. This review has identified opportunities where professionals within the Queensway Centre, A&E, and EPUT could potentially have picked up issues or gleaned information about the nature and relationship between Martine and Adult B.

9.7. The review has identified a need for professionals to be reminded of guidance contained with NICE guidelines and the Southend, Essex and Thurrock Safeguarding guidelines. NICE Guideline 55 states "Professionals should maintain professional curiosity and questioning while building a good relationship" The SET Safeguarding Guidelines April 2019, states "Professional curiosity is the capacity and communication skill to explore and understand what is happening within an adult rather than making assumptions or accepting things at face value. Professional curiosity can require practitioners to think 'outside the box', beyond their usual professional role, and consider circumstances holistically. Curious professionals will spend time engaging with adults. They will ask questions (in an open way) and seek clarity if uncertain and will be open to the unexpected".

9.8. Staff within health including those at the Queensway Centre, A&E and EPUT all became aware that Martine's overdose of the 6th December 2018 was precipitated by a row with Adult B which resulted in him leaving her. This could be seen as a relevant question area for professionals to have explored further with her, especially when considered alongside the other factors detailed in this report relating to Martine's history of mental ill-health, her previous suicide attempts, and dependency on prescription drugs.

Learning Point Three – Safe Environment

9.9. Closely linked to the above is the importance of creating an environment to enable a patient to disclose abuse. At the time, Martine presented in crisis having taken an overdose on 6th December 2018, and during her subsequent assessment with practitioners from the mental health team, the following day, Adult B was allowed to be present. Whilst this could be perceived as Adult B being supportive of Martine in her time of need, it could also be seen as a controlling act which inhibited her ability to disclose abuse to professionals. This is particularly valid if taken together with the fact that Adult B tried to cancel the ambulance that Martine had called reporting her overdose.

9.10. NICE Guidelines and Public Health regulations stress the importance of creating a safe environment to enable patients to disclose domestic abuse. As part of the IMR for SUFHT the author referred to local guidance on Professional Curiosity and NICE Guidelines for Domestic violence and abuse: multi-agency working - Public health guideline [PH50] Published February 2014 with particular reference to Recommendations 5 which states ' Create an environment for disclosing domestic violence and abuse"[12]. The review has identified that the environment could have been better considered to encourage disclosure.

Learning Point Four Tracking of prescriptions

9.11. The review has identified, from entries on notes held within health and from information provided by Adult B, that Martine frequently reported loss of prescriptions and was prescribed further medication without any real challenge. The reason given for this by Adult B was that the drugs were needed to feed their addictions. This could have been in the context of coercive and controlling behaviour by him.

9.12. The expert on medicines commissioned by the Review Panel was asked if they had any recommendation which need to be considered as a result of this case. The expert reported that all GP practices should be moving to electronic prescribing which has functionality for prescriptions to be tracked; this should be embedded as a routine check for all claims of lost

[12] National Centre for Clinical Excellence 2014 – Domestic Violence and Abuse (PH50)

prescriptions especially for vulnerable patients and drugs that can cause dependency/abuse. This forms the basis of a recommendation.

Learning Point 5 - Long term prescription of opioids

9.13. The DHR Panel identified concerns over the long-term prescribing of powerful opioids to Martine, particularly tramadol. The side effects of these drugs can have a serious impact on a persons' ability to function particularly when taken in combination with other drugs and alcohol. Both Adult B and Martine had a dependency on legal and illegal drugs and alcohol.

9.14. The expert commissioned by the panel reported there had been a recent review in 2019 by Public Health England who had published a report on prescribed medicines entitled "Dependence and withdrawal of some prescribed medicines". Which has a number of recommendations contained within for health professionals linked to the dangers of long-term use of opioid drugs.

Learning Point Six – Knowledge linked to the domestic abuse, mental health and substance misuse.

9.15. The DHR Panel have identified, there was a lack of recognition by professionals of the dangers of the combination of mental health, substances misuse and domestic abuse. There is a strong body of evidence available to support the assertion that when these three factors combine, the risk of a person being harmed through domestic abuse or perpetrating an act of domestic abuse is significantly heightened. The panel believe Improving awareness, early identification and responses through further training and education, could be considered beneficial for all professionals across the local CCGs associated

Learning Point Seven – Disclosure of information between call takers and first responders (EEA)

9.16. The review has identified some key information taken by the EEA call takers on 6th December 2018 was not communicated to the first responders or A & E personnel. This related to the fact that Adult B tried to cancel the ambulance called by Martine following her overdose. Clinicians who engage with service users by phone must ensure that any concerns are raised with the attending crew. It is important that all practitioners communicate concerns so that correct decisions can be made in respect of subsequent referrals.

Learning Point Eight – Downgrading on domestic abuse incidents before attendance.

9.17. The review panel considers that the regrading of the incident by the police on the day of the shooting from Priority 1 to 3 was premature given the nature of what was being reported by Martine (Boyfriend being violent and abusive) coupled with the fact that Force Control Room (FCR) Staff were then unable to make contact with her after she had ended the initial call.

10.0 RECOMMENDATIONS

10.1. This section of the report sets out the recommendations made by the DHR Panel:

Recommendation One

All agencies need to consider their internal arrangements for training provision around the subject of coercive control, the effects of trauma within an inter-personal relationship and the key changes being introduced within the forthcoming Domestic Abuse Bill/Act.

Recommendation Two

The SETDAB to deliver a campaign to raise awareness of all professionals concerning the importance of professional curiosity and issues which need to be explored, particularly when dealing with adults who suffer with mental ill-health, and substance or alcohol misuse as they may be factors which heighten the risk of domestic abuse.

Recommendation Three

The Southend University Foundation Hospital Trust Emergency Department to review its procedures to ensure environmental privacy is optimised to promote disclosure from patients, particularly those who are in crisis.

Recommendation Four

All GP practices across SET, should be moving to electronic prescribing which has functionality for prescriptions to be tracked; this should be embedded as a routine check for all claims of lost prescriptions especially for vulnerable patients and drugs that can cause dependency/abuse. (The CCG medicines management team can support the dissemination of this information to all practices).

Recommendation Five

NHS Southend CCG should support Queensway Surgery to develop a process to ensure that all staff at the practice have safeguarding competencies relevant to their roles and responsibilities in line with the requirement set out in the Adult Safeguarding: Roles and Competencies for Health Care Staff First edition: August 2018. Clinical supervision records would provide an excellent reference point for monitoring, audit, and quality.

Recommendation Six

Queensway Surgery should ensure that all staff are aware of the function and application of the S1 vulnerable adults' icon and undertake teaching / refresher sessions and an audit to provide assurance that it is being effectively used.

Recommendation Seven

Queensway Surgery should review and revise the structure and function of the multi-disciplinary and safeguarding meetings so that the care of vulnerable adults has appropriate oversight by the team. This

should include the allocation of a GP/Nurse to act as lead professional for the patient on behalf of the Practice.

Recommendation Eight

Queensway Surgery should continue to explore with EPUT the sharing of relevant information about patients who are under the care of EPUT clinicians to ensure care pathways are managed effective to achieve best quality outcomes for the patient.

Recommendation Nine

The clinical commissioning groups across SET to raise awareness of the 2019 Public Health England report on Prescribed medicines "Dependence and withdrawal of some prescribed medicines" and the recommendations contained within. To also ensure a process is put in place to obtain regular progress reports from the Director overseeing the CCG programme of work associated with the monitoring and prescribing of medications as defined under the report.

Recommendation Ten

All Health and Social Care Professionals to disseminate the learning from this review, to raise awareness of practitioners of the complexities surrounding mental health and substance/alcohol abuse. Practitioners need to be aware that while they do not cause the abusive behaviour, they may be a contributory factor. This aspect should be considered in any routine assessment process when one of more of these factors are present.

Recommendation Eleven

The East of England Ambulance Service should raise the awareness of all telephone clinicians that any concerns raised during a 999 call, should be highlighted to the attending crew. (In this case there was the possibility that the patient was being coerced by the partner not to have an ambulance attend scene following a report of an overdose).

Recommendation Twelve

Essex Police should reinforce to relevant staff within the Force Control Room, the need to fully record within the THRIVE assessment their rationale for downgrading STORM Incident Response Priorities. In particular, the assessment should fully reflect the change in circumstances leading to the Priority regrading.

Recommendation Thirteen

In cases where a 999-call reporting domestic abuse to the police is terminated prematurely, incidents should not be downgraded until contact has been re-established with the caller. This should be reflected in Essex Police Policy Guidelines.