# Bracknell Forest

# Community Safety Partnership

# Domestic Homicide Review DC

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**Report Author: Jerry Oliver July 2013**

V6.1

## Contents

## The Chair of the Domestic Homicide Review

1. Linda Wells was appointed Chair of this Domestic Homicide Review (DHR) by the DHR Panel at its first meeting on 7th September 2011. Linda is the Housing and Community Services Director of Bracknell Forest Homes, a Community based Housing Association. She has worked for Bracknell Forest Homes since 2008 and is independent of the other agencies involved in this Domestic Homicide Review. DC and her husband JC were not tenants of the Association, they owned their own home. .

## The Report Author

2. Jerry Oliver, the Author, has occupied positions as Director of Local Authority Adult, Children and Families and Housing Services, PCT Operational Director (Integration), Chief Inspector in Regulation pre CSCI, NSCI AND CQC and more recently Department of Health North West Regional Policy Lead (England).

3. At present Managing Director of Janjer Ltd, a specialist care and health business consultancy providing UK wide advisory services, including risk management services to insurance underwriters on risk, claim and loss adjusting. Linked with this is a UK wide Assist Service to Policy Holders.

## The Domestic Homicide Review Panel

4. This comprised representatives from Berkshire Women's Aid, Thames Valley Police (TVP), Thames Valley Probation, NHS Berkshire, and Bracknell Forest Council through the Local Safeguarding Children's Board, the Community Safety Manager and the Assistant Borough Solicitor.

## Introduction

5. The referral for consideration of a DHR was made by TVP to the Bracknell Forest Community Safety Partnership (BFCSP). A meeting took place on 7th July 2011 at which the homicide case summary was reviewed and Home Office guidance was considered and concluded that the requirement for such a review was met.

6. This DHR was commissioned by BFCSP in response to the death of DC in November 2010.

7. The review followed the guidance issued by the Home Office in April 2011 for DHR under the Domestic Violence, Crime and Victims Act 2004.

8. The DHR Panel appointed Linda Wells of Bracknell Forest Homes as Chair of the review at its first meeting on 7th September 2011.

9. DC, aged 33 years at the time of her death, was murdered in the matrimonial home in Bracknell on 15th November 2010.

10. On 23rd May 2011 DC's estranged husband JC, aged 44 years at the time of her death, was convicted of her murder and sentenced to serve a minimum of 26 years imprisonment. He was also found guilty of an offence of arson which took place on 14th November 2010.

## Background

11. DC and JC were married and lived at their home address in Bracknell, Berkshire. They had two children during their 16 year relationship, aged 12 and 13 years.

12. In early November 2010, DC and JC separated and DC left the matrimonial home and went to live at her parents' home in Bracknell which is very close to her own home.

13. The children remained with their father as there was insufficient room for them to stay with DC at her parents' home.

14. DC continued to visit and was in regular contact with the children and JC. She intended to seek 'Local Authority' accommodation for herself and her children.

15. The Berkshire Fire Brigade received a call at 21:12 on 14th November 2010, reporting that a Land Rover was on fire at a location very close to JC's home. The fire brigade attended and concluded that the fire had been ignited deliberately.

16. JC was alerted to the fire by someone who recognised the vehicle and called at her home that same night (14th November 2010) to tell him.

17. The next morning, 15th November 2010, a police officer visited her home address to follow up on the incident and inform the owner. The officer spoke to JC about the fire and JC directed him to DC's parents' home, where the officer saw DC and informed her of the theft and arson of her Land Rover.

18. In the afternoon of 15th November 2010, DC returned to the matrimonial home at to collect the insurance documents for the Land Rover. This was the last time she was seen alive.

19. Late in the afternoon on Monday 15th November 2010, Thames Valley Police (TVP) were contacted by DC's mother - JS, who was concerned for her daughter's welfare. She had not had contact with DC since 2pm when she had dropped her home address to collect some paperwork.

20. JS was surprised that the children had not been collected from school and they had received a text from their father telling them to go to their grandparents'

home. This had not happened before without explanation and raised concerns with JS.

21. JS went to DCs home but was unable to obtain a response from the property or to gain access. The blinds were drawn and the front door appeared to be barricaded. JC's car was parked outside the property. JS called the police.

22. The police attended and forced entry. DC was found in the lounge area of the house with severe head injuries. She also had a ligature around her neck. She was confirmed dead by paramedics at the scene of the crime. JC was present at the scene and was arrested on suspicion of murder.

23. JC was later charged and remanded to appear at Court. On 23rd May 2011, JC was found guilty of the murder of DC and sentenced to serve a minimum of 26 years imprisonment. He was also found guilty of an offence of arson which took place on 14th November 2010.

24. JC appealed against his conviction and sentence. The appeal was heard in November 2011, the result of which was that JC's sentence was reduced from 26 years to 20 years.

25. The arson incident related to DC's vehicle, which was described by her mother as being 'her pride and joy'.

26. DC's mother and brother both indicated in their statements to the police that DC believed that JC was responsible for the theft and arson of her vehicle. Her daughter SC also indicated in her statement to the police why she believed her father was responsible for the fire.

27. DC had left JC approximately two weeks prior to her death. A number of witnesses described JC's 'controlling' and disrespectful behaviour towards DC during their relationship and her subservience towards him. There is reference to DC having a black eye on one occasion. There is also reference to an incident when JC was seen to drag his wife into the house by her hair. This information came from conversations by the DHR panel with family and friends of DC. The report of a black eye came from DCs mother. This incident, including another of being dragged by the hair were never reported and it is not now possible to verify dates and places due to the passage of time.

28. There is evidence that DC was in an extra-marital relationship which started in October 2010 before she left her husband. DC's mother stated that only a week or so before her death, DC informed her that she had admitted to JC that she had been having an affair. The person whom it is alleged was having an affair

with DC was a witness in the police investigation but was not contacted by the DHR panel.

29. The children are now cared for by their maternal grandparents, at their home in Bracknell.

## Terms of Reference for the Review

30. The purpose of the review is to:

- Establish the facts that led to the incident in November 2010 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 including the welfare of the children.
- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.
- Establish a SCR should serious concerns over safeguarding come to light.
- Establish whether the agencies or inter-agency responses were appropriate leading up to and at the time of the incident in November 2010
- 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.
- DHRs are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

## Scope of the Review

31. The review:

- Considered the period of two calendar years prior to the event, subject to any information emerging that prompted a review of any earlier incidents or events that are relevant.
- Requested Internal Management Reviews by each of the agencies as defined by Section 9 of the Act, and invited responses from any other relevant agencies or individuals identified through the process of the review.
- Sought the involvement/information of the family, employers, neighbours and friends to provide robust analysis of involvement.
- Produced a report that summarised the chronology of the events, including the actions of the agencies involved, analysis and comments on the actions taken and made any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.

- Produced a report subject to responding sensitively to the concerns of the family, particularly in relation to the inquest process, the internal management reviews being completed and the potential for identifying matters which may require further review.
- There was a full appeal against conviction and sentence which resulted in a reduction in the sentence. This caused some delays in this DHR moving forward.

## What are Domestic Homicide Reviews

32. DHRs are part of the Domestic Violence, Crime and Victims Act 2004 and became law from 13th April 2011. They do not replace, but are in addition to, the inquest or any other form of inquiry into the homicide.

33. The main document to guide the review team was the guidance[1] issued by the Home Office as statutory guidance under section 9(3) of the Domestic Violence, Crime and Victims Act (2004). The act states: "domestic homicide review" means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by—

    (a) A person to whom he was related or with whom he was or had been in an intimate personal relationship, or

    (b) A member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.

34. It is clear that the death of DC falls within this definition.

35. This review was conducted between September 2011 and October 2012. During this period the Review Panel met on the 7th September 2011, 24th October 2011, 5th December 2011, 9th January 2012 and 29th October 2012.

## Purpose of a Domestic Homicide Review

36. The purpose of a DHR 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;

[1] http://www.homeoffice.gov.uk/publications/crime/DHR-guidance

- 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; and

- Identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

## Establishing a Review Panel

Core Members of the review panel were:

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|---|---|
| • Carol Bell | Berkshire Women's Aid |
| • Ian Boswell | Community Safety Manager, BFC |
| • Simon Bull | Asst Borough Solicitor, BFC |
| • D/I Jackie Phillips | TVP Protecting Vulnerable People Unit (PVPU) |
| • Karen Roberts | BFC representing LSCB |
| • Jonathan Rowlands | Thames Valley Probation |
| • Angela Snowling | NHS Berkshire East |
| • Linda Wells | Bracknell Forest Homes |
| • Sophie Wing-King | TVP/BFC (Domestic Abuse Co-ordinator) |
| • Bev Searle | NHS Berkshire (Cluster) Director Safeguarding |
| • D/C Kylie West | TVP |

## The Review Report itself and what happens to this

37. The methodology is as follows:

    - Background to the DHR

    - Consideration of single agency/individual reports, highlighting lessons learnt and recommendations

    - Key points of note

    - Main recommendations and conclusions.

    An integrated agency chronology has also been drawn together and this is included as Appendix A to this report.

38. The tendency over the last few years has seen these reports growing in detail and sometimes arguably including detail and complexity of style that does not allow the key issues to surface readily. This report is designed to be concise and pull the lessons learnt from all the agencies involved into a composite

document. Enabling all interested parties to readily understand the key organisational learning points and corrective actions and to hold parties accountable for making improvements where these have been acknowledged and agreed.

39. The Home Office guidance states that "Publication of Overview Reports and the Executive Summary will take place following agreement from the Quality Assurance Group at the Home Office and should be published on the local CSP web page."

40. The Overview Report aims to bring together and draw overall conclusions from the information and analysis contained in the Independent Management Reviews (IMR). The review of these IMRs and ancillary information also raised questions and actions for taking forward during the life of the Panel.

41. The Overview Report makes recommendations for future action which the Review Panel has translated into a specific, measurable, achievable, realistic and timely (SMART) Action Plan. This is referenced in Appendix B.

## Individual Management Review Reports (IMR)

42. The Chair of the Review Panel wrote to the senior manager in each of the participating agencies to commission from them an IMR. The IMRs form part of this report.

43. The aim of the IMR is to allow agencies to look openly and critically at individual and organisational practice and the context within which people were working, and to see whether as a result of the homicide changes could and should be made. To also identify how those changes will be brought about and to identify examples of good practice within those agencies. **The two key judgements are predictability and preventability.**

## Other Authorities involved and contacted

44. Due to the gender of the deceased, the Berkshire Woman's Aid organisation was contacted.

45. Neither the deceased or the perpetrator were subject to a Multi-Agency Risk Assessment Conference (MARAC)[2] and the perpetrator was not subject to Multi-Agency Public Protection Arrangements (MAPPA)[3]

[2]**The MARAC** is a victim-focused meeting where information is shared on the highest risk cases of domestic abuse between criminal justice, health, child protection, housing practitioners, IDVAs (Independent Domestic Violence Advocate) as well as other specialists from the statutory and voluntary sectors. A safety plan for each victim is then created.

[3]**MAPPA** is the name given to arrangements in England and Wales for the "responsible authorities" tasked with the management of registered sex offenders, violent and other types of sexual offenders, and offenders who pose a serious risk of harm to the public. The "responsible authorities" of the MAPPA include the National

46. As far as the Review Panel could ascertain the victim did not have contact with any domestic violence organisation.

## Family involvement (general)

47. The review did involve the family of the victim, taking account of who the family wished to have involved as lead members and to identify other people they thought relevant to the review process.

48. The review did seek to agree a communication strategy that kept the family informed, if they so wished, throughout the process. The review did seek to be sensitive to their wishes, their need for support and any existing arrangements that were in place to do this.

49. The review did seek to identify the timescale and process of the Coroner's inquest and ensure that the family were able to respond to this review and the inquest, avoiding duplication of effort and without undue pressure.

## The Family (specific)

50. Initial contact was made with DC's mother via AW, a TVP Family Liaison Officer (FLO) in January 2012. After the re-trial, the FLO explained the purpose of the DHR and invited her to contribute to the review. She agreed to have a telephone conversation with the chair of the DHR.

51. LW, Chair of the DHR, spoke with DCs mother on 3rd February 2012 and reiterated the reason for the contact and the purpose of the DHR.

52. DCs mother was asked, if in hindsight, she could think of any intervention or action agencies could have taken which may have prevented DC's death or could be applied as learning for the future.

53. DCs mother said that she was not aware of the involvement of any agencies prior to DC's death. She did not think DC had asked for any help and felt she had been reluctant to admit to any problems.

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Probation Service, HM Prison Service and England and Wales Police Forces. MAPPA is co-ordinated and supported nationally by the Public Protection Unit within the National Offender Management Service. MAPPA was introduced by the Criminal Justice and Courts Services Act 2000 and strengthened under the Criminal Justice Act 2003.

54. DCs mother was aware of what she considered to be JC's 'controlling behaviour'. She mentioned that DC had told her that JC had not liked DC going out to meet friends at South Hill Park in the evening. DC had been anxious about going home if she was later than expected.

## Points of note

55. DCs mother and her husband took over the care of the children following their mother's death and their father's imprisonment. Immediately after the event there was no financial support available to help with clothing and bedding for the children. As a retired couple, their income was very limited and DCs father returned to part-time work to help provide for the children's needs. DCs mother also had to stop work early to look after the children. The family feel that their need for financial support was not adequately recognised and that they have struggled to manage this burden on top of the tragic loss of their daughter.

56. DCs mother did not think that there was anything agencies could have done prior to the tragic incident, but she did say that she felt more could be done to support the victim's family afterwards. In particular assistance with coordinating the various agencies involved with any support. DCs mother said that it was over a year that they waited for some of the agencies to complete their processing of assistance assessment.

57. LW promised to raise support and its co-ordination to the grandparents with the Director of Children, Young People & Learning.

58. The support to the grandparents raises issues for the Local Authority and a recommendation arising from this report is for the Director of Children, Young People and Learning to review what support and lead agency role should be considered for Carers in these circumstances. For example the Authority in Safeguarding calls agencies together and effectively is the lead agency coordinating and overseeing progress. It seems that where in exceptional circumstances, such as this, the safeguarding role of the Authority should be considered more actively as a preventive action.

## Thames Valley Police (TVP)

59. In order to ascertain any involvement of TVP for the relevant time period covered by the review (15th November 2008 to 15th November 2010) all appropriate databases and systems, listed below, were checked for information relating to the above people.

60. JC first became known to TVP in 1983 for low level offences not related to this review. He has no convictions relevant to this review.

61. At 21.36hrs on Sunday 14th November 2010 a call was made to TVP reporting a vehicle fire in Bracknell. The vehicle was registered to DC.

62. TVP made contact with JC and DC on the morning of the 15th November 2010 in connection with an incident involving DC's car.

63. This incident was graded as a 'By Arrangement' incident and was deferred for attendance by TVP control room until daylight hours the following morning.

## Point of note

64. In this case it is important to remember that there had been no incidents of a similar nature in the vicinity recently reported, there were no further calls regarding the vehicle until the following morning and there was no suggestion that there were any immediate actions to be carried out at the scene. Also DC was not known to TVP as a victim of domestic abuse and there was no suggestion that this was related to any domestic related incidents.

65. PC1 made contact with the local Scenes of Crime Office (SOCO) and agreed that there appeared to be some forensic potential on and around the vehicle and requested that it be recovered for SOCO examination.

66. After the vehicle had been recovered at 09.46hrs, he attended the address DC in order to speak with her as the vehicle was registered to this address.

67. At the address PC1 was met by JC who advised him that DC no longer lived at the property and that she and JC had separated. After a conversation with JC about the vehicle, DC's parents' address was passed to him and he left in order to speak to her.

68. PC1 states that JC was curious about the vehicle fire but no suspicions were raised. JC confirmed that the vehicle belonged to his wife and said that the car was like DC's 'baby' so she would be very upset.

69. When PC1 arrived at DC's parents' address he was greeted by DCs mother. PC1 asked DC some questions in relation to the vehicle and when she had last seen it. DC said that it had been parked locally and that she still had the keys in her possession. She gave no indication to him that she suspected JC to be involved and raised no other issues whilst he was with her.

70. At 16.28hrs on the 15th November 2010, TVP received a telephone call from DCs mother as she was concerned for the welfare of DC. She was at the home address of DC with her two grandchildren. She informed the operator that the

children should have been collected from school by their father JC. They had received a text message from him asking them to go to her house instead, which was also concerning as she had not been made aware of a problem. DC had been dropped at her home address at approximately 2pm by her mother so that she could collect some paperwork for her car. She said she would collect the paperwork and return to her mother's house soon after.

71. The curtains were drawn, the doors were locked and there was a chair blocking the front door. This was very worrying and she requested Police attendance as soon as possible.

72. At 17.14hrs officers reported that they could see movement inside the property and at 17.18hrs officers forced entry to the house. It was very quickly established that there was a deceased female in the property. The female was identified as DC and later that afternoon, JC, who was also in the property, was arrested on suspicion of her murder. He was interviewed, charged with the offence and later remanded into custody awaiting trial.

73. On the 23rd May 2011 he was found guilty of arson to DC's car on the 14th November 2010 and her murder on the 15th November 2010. He was sentenced to a minimum of 26 years imprisonment.

## Points of note

74. During the investigation into DC's murder a number of statements were taken from relatives, friends and acquaintances of DC and JC. These statements were taken in order to gain background knowledge of the couple and to establish whether any other incidents had been witnessed between them that may be relevant to the investigation.

75. DC was not known to police and had no previous cautions or convictions.

76. There was no domestic violence history recorded on TVP information databases between JC and DC and no concerns raised for the welfare of the children JC or SC.

77. The crucial point is whether the delay in attendance by the police to DCs home address in response to the call from her mother could have had any bearing on whether or not it might have been possible to save DCs life. TVP consider that DC was already dead by the time the officers arrived although the officers / staff in the control room would not have known this. Following an internal police investigation two members of TVP staff have been disciplined and one of them has subsequently resigned. TVP processes were found to be sound but in this case they had not been fully complied with.

78. TVP were not aware of any domestic history between JC and DC. There were no concerns raised for DC's welfare when she was seen by police on the morning of the 15th November with regards to the arson attack on her vehicle.

79. TVP were not aware of any information that could in any way have prevented her death.

## Recommendations

80. There are no recommendations arising out of this report.

## Bracknell Forest Council, Children, Young People & Learning Directorate

81. An IMR was produced by the Children & Families Manager, Children, Young People & Learning Department, Bracknell Forest Council.

82. The children in the family are:
    a. A girl in year 8 at the time of mother's death
    b. A boy in year 7 at the time of mother's death

83. Both attended a school in Bracknell

84. The IMR looked at the school files for both children and incorporated discussions with the head teacher of the school where the children attended at the time of their mother's death and have continued to do. Also, the head teacher of the primary school where the children attended up to the end of academic year 6 and also where DC worked some years before her death.

85. Also ascertained from the records held by BHPS that DC's employment records were as follows:
    a. 1992-1998 Hilton Hotel
    b. 2001-2002 Sainsbury's
    c. 2004-2007 Primary school School

86. There is no information about the gaps in the employment history nor is the reason for her leaving the school known.

87. AH reports that there were no concerns about the children. He saw both parents at events regarding the children, but not often together. AH was not aware of any marital/domestic issues, neither from DC as a parent nor as an employee.

88. In respect of the children at their secondary school, reports that there were no concerns about the children. The school had been made aware of the separation of the parents by DC.

89. The school files in respect of both children contain records from the primary school which is only about academic assessment and achievement and no areas of concern and no communication with parents.

90. In October 2009 one of the children was referred to the school's Learning Support Centre for support in building her self-esteem and confidence. She was at that time experiencing some friendship issues and finding the homework too much. Both the daughter and her mother agreed to the additional support from which she benefitted.

91. In February 2010 a letter was sent to Mr & Mrs C informing them that their daughters attendance was only 89.62%. As this period was less than half-way through the academic year no conclusion can be drawn from the absence and any connection to concerns in the home.

92. Overall the daughters attendance record shows that it was 95.7% for 2008/9 and 94.05% for 2009/10 and for 2010/11. She had no absences prior to the death of her mother.

93. In respect of the son's the school file contains records from the primary school which is only about academic assessment and achievement and no areas of concern and no communication with parents.

94. Overall the son's attendance record shows that it was 93.55% for 2008/9 and 94.65% for 2009/10 and for 2010/1. He had only one day's absence prior to the death of his mother.

## Conclusion

95. The IMR concludes that there were no known safeguarding concerns for this family.

## Point of note

96. It is quite common for children who are concerned about a parent to want to be at home with the parent. Both children had good school attendance and are reported as not showing any concerns in school.

## In Summary

97. There are no direct points concerning matters which have a bearing on the predictability or preventability of this domestic homicide as far as Bracknell's Children, Young People & Learning Directorate is concerned. The support to the grandparents raises issues for the Local Authority. A recommendation arising (covered earlier in this report) is for the Director of Children, Young People & Learning to review whether in such circumstances there should be a meeting called under Safeguarding protocols to ensure the appropriate support that may be required has been assessed and is being actioned in a timely manner.

## Recommendation 1

98. The Director of Children, Young People & Learning to review whether in such circumstances there should be a meeting called under its Safeguarding protocols to ensure that any appropriate support that may be required by carers has been assessed and is being actioned in a timely manner.

## NHS Berkshire

99. An IMR report was received from this agency. The area considered was as follows:
    a. A review of the GP notes (both handheld and electronic data) by a consultant in public health, and with the aid of a research governance nurse.

100. When considering the health records for JC it was noted that his father had a history of alcohol dependency and violence to his mother. JC's records do not show evidence of substance abuse on his part. There is also some periodic treatment for anxiety on a number of occasions and the prescription of symptomatic medication for this.

101. There is also one recorded event in 1995, where discussions with his GP followed the report of relationship difficulties. He was offered a referral to the community mental health team. However, this was declined. It is clear from the records that appropriate assessment for suicidal intent and self-harm occurred on four occasions, but there was never any sign that these were likely to become associated with domestic violence.

102. For DC, whilst there were noted routine medical visits, these were not relevant to this review. It was agreed that any such ordinary medical information would not be the subject of review by this domestic review panel.

103. In conclusion, it was considered that DC constituted a standard presentation for health contacts that had occurred. There was no information or indication that she was a person being abused.

### In summary

104. The review of the GP notes clarified that there was no evidence that was available to the GP to enable any prediction or prevention of this domestic homicide.

105. However, the review noted, as is common with the vast majority of GP practices, that a good number do not have an Adult Safeguarding policy or protocol. This therefore forms a recommendation arising out of this report. However, this does not have a direct bearing on the predictability or preventability of this occurrence related to any health contacts that had occurred.

### Recommendation 2

106. All GP practices within Bracknell Forest should develop an Adult Safeguarding policy. The policy should be compliant with the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010, particularly regulation 11, and in line with the Berkshire Safeguarding Adults policy.

### Berkshire Women's Aid

107. There was no IMR submitted by this organisation. There was involvement by this organisation on the DHR Panel. No information was known about either DC or JC.

### Point of note

108. There are no points of note.

### Recommendations

109. There are no recommendations.

### Work

110. A telephone conversation was held between LW and DC's supervisor, MF, at the supermarket where she had worked.

111. MF was a trainee manager and team leader at the time of DC's death. DC worked what is known as the 'twilight shift', 8pm to 12 midnight.

112. MF said he did not know DC very well; they had only met about four times. He was not aware that DC had any problems and her death was very much 'out of the blue' and a great shock to everyone.

113. He did recall that DC had requested a change in shifts about three weeks before her death to enable her to spend more time with her children. He thought this was a perfectly reasonable request and the company were trying to make changes to accommodate her request.

114. MF said he would ask others in the team who may have been closer to DC if they had any other information which may be of assistance to the review and provide them with LW's contact number  No further contact was received.

### Point of note

115. There are no points of note.

### Recommendations

116. There are no recommendations.

## Main recommendations in Summary

### Multi-Agency recommendations

There are no recommendations arising out of this report.

### Single Agency recommendations

**Bracknell Forest Council, Children, Young People and Learning Directorate**

**Recommendation 1:** The Director of Children, Young People & Learning to review whether in such circumstances there should be a meeting called under its Safeguarding protocols to ensure that any appropriate support that may be required by carers has been assessed and is being actioned in a timely manner.

**NHS Berkshire**

**Recommendation 2:** All GP practices within Bracknell Forest should develop an Adult Safeguarding policy. The policy should be compliant with the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010, particularly regulation 11, and in line with the Berkshire Safeguarding Adults policy.

## Appendix A Chronology

**CHRONOLOGY OF AGENCIES**

***Berks East PCT now known as NHS Berks**

| Event | Date/ Time | Agency | Form of contact | Significant Event | Comment |
|---|---|---|---|---|---|
| 1. | | *Berks East PCT | Director of Public Health | | Learning point from discussion with practice manager; there is no Adult Safeguarding policy or protocol in the practice. They are not alone in this. Is this an opportunity to review and ensure all practices have a copy? |
| 2. | 14.11.10 21:36 | Thames Valley Police | Call from Berkshire Fire and Rescue Service (URN 1339 14.11.10) | Caller from Berkshire Fire & Rescue Service contacted TVP informing them that they had a unit at a location in Bracknell which was dealing with a vehicle fire. The registration number of the damaged vehicle was passed to the call taker. The caller also informed the call taker that the vehicle was not completely burnt out. Their reference was passed as XXXX and the call was ended.<br><br>The vehicle was registered to DC in Bracknell. Her | The call was taken by a staff member in Milton Keynes Control Room and was graded by him as 'By Arrangement'.<br><br>The vehicle was left in situ at the location overnight and no contact was made or attempted with the owner. |

| Event | Date/ Time | Agency | Form of contact | Significant Event | Comment |
|---|---|---|---|---|---|
| | | | | telephone number was recorded in the log due to a previous call received from her on 05.10.10 | The incident was attended on the 15.11.10 by a local officer to conduct enquiries with the registered owner. |
| 3. | 15.11.10 16:28 | Thames Valley Police | Call to Police (URN 1009 15.11.10) | JS called Police as she was concerned for her daughters' welfare. Her daughter's name was given as DC.<br><br>JS informed the call taker that she was standing outside of DC's home address with her two children who had not been collected from school by their father that afternoon as planned. She explained that DC was separated from her husband, JC.<br><br>DC was last seen at approximately 2pm that same day having been dropped at the house by JS to collect some paperwork for her car.<br><br>The house was locked from the inside and the curtains were drawn. There was also a chair blocking the front door and no answer when she called the house telephone or DC's mobile phone. | This incident was graded by the call taker as Immediate attendance to the house.<br><br>Entry was forced and DC was discovered dead in the lounge area. She had a ligature around her neck and severe head injuries.<br><br>JC was found in the loft and was arrested some time later that day on suspicion of DC's murder.<br><br>He was charged and remanded in custody. |

## Appendix B Action Planning Bracknell Forest Community Safety Partnership: DC Domestic Homicide Review July 2013

| Recommendation | Scope of Recommendation i.e. Local National | Action to take | Lead Agency | Key Milestones achieved in enacting recommendation | Target date | Date of completion and Outcome |
|---|---|---|---|---|---|---|
| 1. The Director of Children, Young People & Learning to review whether in such circumstances there should be a meeting called under its Safeguarding protocols to ensure that any appropriate support that may be required by carers has been assessed and is being actioned in a timely manner. | Local | Director of Children, Young People & Learning to review what support can be considered for the grandparents. | Bracknell Children, Young People & Learning Directorate | Director to allocate appropriate Social Work contact to review any needs that may need direct or signposting assistance. | November 2013 | |
| 2. All GP practices within Bracknell Forest should develop an Adult Safeguarding policy. The policy should be compliant with the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010, particularly regulation 11, and in line with the Berkshire | Local | Establishment within the Primary Care Cluster Group consideration of policy and protocols for Safeguarding across the GP sector. | NHS Berkshire | Policy on Safeguarding policy and protocols across the GP clusters introduced. | To be established | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Safeguarding Adults policy. | | | | | | |

**Appendix C**

Home Office

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Timothy Wheadon
Chief Executive of Bracknell Forest Council
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Berkshire

RG12 1AQ

7 February 2014

Dear Mr Wheadon,

Thank you for submitting the Domestic Homicide Review (DHR) report from Bracknell Forest to the Home Office Quality Assurance (QA) Panel. The review was considered at the QA Panel meeting in January.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. In terms of the assessment of DHR reports the QA Panel judges them as either adequate or inadequate. It is clear that a lot of effort has gone into producing this report, and I am pleased to tell you that it has been judged as adequate by the QA Panel.

The QA Panel would like to commend you on your diligence in conducting this review despite the fact that the death in this case preceded DHRs becoming a statutory obligation.

There were some issues that the Panel felt might benefit from more detail or amendment, and which you may wish to consider before you publish the final report:

- The report would benefit from some more text to clarify what barriers to seeking help may have existed in the eyes of the victim, before the tragedy occurred. For example, paragraph 27 of the report says a number of witnesses described the perpetrator's 'controlling' and disrespectful behaviour towards the victim during their relationship and her subservience towards him. There is reference to the victim having a black eye on one occasion, and a reference to an incident when the perpetrator was seen to drag his wife into the house by her hair. Reference to the potential barriers will help to complete the picture of the victim's perspective following these references to the control and violence suffered by the victim;

- There is evidence that the victim was in an extra-marital relationship which started in October 2010 before she left her husband. The victim's mother stated that only a week or so before her death, the victim informed her that she had admitted to the perpetrator that she had been having an affair. The report would be improved if there was some text on attempts to contact this person or whether they declined to contribute, as well as some clarification in the report regarding any friends that were approached in this process would also be helpful;

- Please include some text to clarify how the Chair qualifies as independent for the purposes of this review as required by the Statutory Guidance on the conduct of DHRs; and,

- It would be helpful to include some more text regarding the police response time including the Chair's consideration of whether the response time impacted on the victim's safety.

We do not need to see another version of the report, but I would ask you to include this letter as an appendix to the report when the lessons and actions from the Action Plan are disseminated.

Thank you.

Yours sincerely,

Christian Papaleontiou, Acting Chair of the Home Office Quality Assurance Panel

Head of the Interpersonal Violence Team, Violent Crime Unit