LEARNING
FROM A JOINT
DOMESTIC HOMICIDE REVIEW / SERIOUS CASE REVIEW

Child CC

www.surreyscb.org.uk

The SSCB commissioned a Serious Case Review in relation to a 14 year old child known, for the purposes of the review, as Child CC.

Synopsis

On 17 June 2015 the child's father collected the child from school and later that evening emailed the school to inform that due to a family tragedy Child CC would be absent from school until 29 June 2015. In the early hours of 18 June 2015 father travelled to France, where, on 27 June 2015, disclosed to a friend the deaths of his wife and daughter. On 28 June 2015, father took his own life in France and on 29 June 2015, the friend contacted Surrey Police to advice of father's suicide and register concern about the wellbeing of mother and Child CC. On the same day the school contacted Surrey Police to report concerns about Child CC as she had not returned to school. Police attended the home address and found the mother and Child CC dead inside the family home. In November 2015 the Coroner returned verdicts of unlawful killing in respect of mother and Child CC.

Good Practice

- The school informed police as soon as the deadline for Child CC's return to school lapsed.
- When mother contacted Surrey Police's contact centre to seek advice in relation to domestic abuse and then terminated the call, police staff escalated the terminated call to the Force Control Room for police deployment. There was a deficit of information to establish whether there was a risk to life, risk of serious injury, or whether any party required medical attention so the decision to deploy a police officer to the home address was critical.

Main Themes

The main themes identified in this review are as follows:

1. Although father had contact with police on one occasion and mother on three, they were not asked if they had any children. This meant that Child CC's presence within the home was not identified and that any associated risks to her or needs arising from domestic abuse between the parents were not assessed.

2. Surrey Police identified that they gave inaccurate information to mother when she contacted police to seek advice in relation to domestic violence. This initial contact caused the relationship between mother and police to deteriorate with each further contact and resulted in a breakdown of any meaningful communication. Therefore the opportunities to provide mother with sound advice about her options and safety were lost. Likewise, it made any likelihood of holding father to account for any potential offences impossible. This highlights the need for police contact centre staff to be equipped to undertake crucial initial responses to vulnerable victims with accurate and up to date information relating to domestic abuse as well as a clear pathway to support agencies outside of and independent from the criminal justice remit.
3. When police attended the home address following a terminated call about domestic abuse and mother was absent, they failed to establish if mother was absent due to separation between the parents. At the same time, they found father about to depart as well. This was a missed opportunity to establish whether mother's absence and father's imminent departure, was due to separation and likely to trigger an escalation in father's abusive behaviour and increase the risk of harm to mother and child.
4. The Domestic Abuse, Stalking and Harassment (DASH) risk assessment was not completed during this contact by police officers due to very limited information. The form could have been at least partially completed with the information available.
5. The police response to mother's approach for help did not realise its potential to activate other parts of a wider system to respond to the needs that arose from father's abuse of mother. A critical opportunity to offer/refer mother to a specialist domestic abuse support service was missed. Perhaps, an additional referral pathway between police and domestic abuse support services in cases where the DASH risk assessment has not been completed would have been helpful.
6. Private health care providers that were involved with the family failed to provide sufficient information to the review.

Recommendations for the SSCB, the Community Safety Partnership (CSP) and partner agencies

1. The CSP to analyse their existing response to domestic abuse and seek to develop a more complete and enhanced approach to this issue through the mechanism of a Coordinated Community Response (CCR) to domestic abuse.
2. The local borough to develop and trial individual and community interventions using the concept of co-production, to enhance the borough's response to victims of domestic abuse.
3. Surrey Police to ensure that the agreed intention of providing police information about vulnerable people to relevant agencies, including schools, is promulgated with urgency.
4. The CSP to undertake a cost-benefit analysis to establish the viability of implementing an additional referral pathway between police and domestic abuse outreach services in cases where the DASH risk assessment tool has not been successfully completed.
5. Surrey Police to deliver training for contact centre staff to ensure a sound grasp of the dynamics of domestic violence and to equip them with the skills and information necessary to respond appropriately to victims of domestic abuse.
6. Surrey Police to develop clear pathways to specialist domestic abuse support services and related agencies.
7. Surrey Police to provide enhanced risk identification and awareness training to ensure Public Protection Unit supervisors have adequately informed oversight of domestic abuse cases.
8. Surrey Police to use this review process and the development from the recommendations to audit its policies and practice to ensure the developments are embedded in practice (within six months of publication of the report).
9. The Independent Secondary School to integrate domestic abuse awareness into safeguarding training for all staff (and ensure those staff already trained in safeguarding receive that training).
10. The Independent Secondary School to integrate the Spiralling toolkit[1] into PSHE (personal, social, health and economic) education.

[1] http://thehideout.org.uk/wp-content/uploads/2015/07/spiralling_toolkit.pdf

11. The local NHS General Practice to request the Joint Commissioning Board to commission the IRIS programme within the area.
12. Debt advisory services to develop a system where those individuals with a County Court Judgements (or similar) relating to debt are provided with information about domestic abuse support services and support to assist in the resolution of the case.
13. HM Government to develop the statutory guidance for Domestic Homicide Reviews (DHR) to specifically include private medical care and oblige such organisations to participate in the DHR process.
14. NHS England to respond to the gaps that emerge between private and national health care providers which may threaten the safety of adult and child survivors of domestic abuse.

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