Safer Somerset Partnership

Domestic Homicide Review Overview Report Executive Summary regarding Diane who died in February 2020

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A message of condolence

The Domestic Homicide Review Panel wishes to express its condolences to the family and friends of those affected by the events described in this report. The panel hopes that the process will provide some answers to their questions.

Introduction

1. This Domestic Homicide Review (DHR) Overview Report examines agency responses and support given to Diane, who has been a resident of Somerset, prior to her death in February 2020.

2. Diane's death was notified to Safer Somerset Partnership (SSP) in March 2020. At the same time the death of her husband, from whom she had been estranged was also reported.

3. Diane had returned to Somerset from Ireland to meet friends and collect some personal belongings from the former marital home following the break up with her husband Jeremy. This included collecting two dogs. She had been living in Ireland for a short period, with her new partner. She arranged for her friend, to go to the house with her.

4. While at the house, having packed things in her car, Diane wanted to take the dogs for a short walk before the car journey. Jeremy went with her. Her friend reported that a few minutes later, Jeremy returned to the house, with a shotgun and said that he had shot Diane. Her friend, not initially believing this, asked Jeremy where Diane was, and he reportedly took her to show her Diane's body. Her friend reported to the DHR Chair that she identified that it was Diane, and that she had a gun shot wound. It was not clear to her if Diane was dead, and it is reported she died later, before the ambulance service arrived.

5. Jeremy then took Diane's friend back to the house and locked her in the stable block. She was able to see him and reported that she observed him attaching hosepipes to the car exhaust, which he was unable to do. Jeremy then returned to the locked stable to tell Diane's friend that he would now try to shoot himself. After five minutes he returned and was observed to saw off the barrels of the shotgun. He then went out of sight and she then reported hearing a muffled shot. She waited around 15 minutes and then managed to get out of the stable by prising a grille from the window. She then called the police.

6. A criminal investigation was initially commenced, as Jeremy did not die immediately but later succumbed to his injuries in hospital. An update on the status of the investigation has been provided to the DHR by the police and is as follows: “Given that the incident was self-contained with no other parties involved, and the main suspect is deceased, there can clearly be no prosecution. Therefore the matter will proceed in due course to the Coroner to hold an inquest into their deaths”.

The DHR process

7. This DHR was commissioned because it meets the definition detailed in paragraph 12 of the Multi-Agency Guidance for the Conduct of Domestic Homicide Reviews (Home Office 2016). The review has followed the Statutory Guidance for Domestic Homicide Reviews under the Domestic Violence, Crime and Victims Act 2004.

8. The police made the referral to the Safer Somerset Partnership (SSP) on the day after Diane’s death. The SSP commissioned the DHR.

9. No parallel reviews were undertaken or were in train during the period that the DHR took place.

10. A first panel meeting was held in September 2020, following a period of scoping and then Individual Management Review (IMR) completion and submission. The process was concluded in May 2021. The DHR panel met virtually four times, as well as additional discussions by teleconference. The Chair also held discussions by phone with the DHR lead within Safer Somerset Partnership.

11. The Domestic Homicide Review has been conducted in line with the expectations of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2013. This guidance is issued as statutory guidance under section 9(3) of the Domestic Violence, Crime and Adults Act 2004. It has since been updated and was republished in December 2016.

Contributors to the Domestic Homicide Review

12. Individual Management Reports (IMRs) were requested from the agencies that had been in contact with or providing services to Diane and Jeremy. The objective of the IMRs which form the basis for the DHR was to provide as accurate as possible an account of what originally transpired in respect of the incident itself and the details of contact and service provision by agencies with both the subjects of the DHR.

13. The IMRs were to review and evaluate this thoroughly, and if necessary, to identify any improvements for future practice. The IMRs have also assessed the changes that have taken place in service provision during the timescale of the review and considered if changes are required to better meet the needs of individuals at risk of or experiencing domestic abuse.

14. Three agencies contributed to the review through the submission of Individual Management Reviews and the provision of initial scoping information. Those agencies were:

- Avon and Somerset Police
- The GP practice, completed by Somerset Clinical Commissioning Group
- Somerset NHS Foundation Trust

15. The agencies identified above each provided IMRs that were reviewed by the panel and used by the panel in reaching their conclusions

Other contributors to the DHR

16. Diane's partner in Ireland Robert, and her friend Jenny who was present at the time of the murder contributed to the review, and took part in consultative interviews in December 2020. Another friend, Sophie was interviewed in February 2021 and another friend, Sarah, provided information. These names are pseudonyms chosen at random, but agreed with those concerned prior to the report being finalised.

The Domestic Homicide Review Panel Members

Agency	Representative
Independent Chair	Steve Appleton
Avon and Somerset Police	Andrew Sparks
Clinical Commissioning Group	Charlotte Brown
Clinical Commissioning Group presenting the IMR for the GP practice	Joanne Nicholl
Safer Somerset Partnership (SCC Public Health)	Suzanne Harris
Somerset Integrated Domestic Abuse aService	Leanne Tasker (to Dec 2020/ Natalie Giles (From Dec 2020)
Somerset Partnership NHS Foundation Trust	Julia Mason

17. The members of the panel were independent and had no prior contact with the subjects of the DHR or knowledge of the case. The GP from the GP practice attended the panels and gave valuable insights but did have prior knowledge of both parties, and therefore the independence was provided by the CCG writing the IMR.

The Overview Report author

19. The Independent Chair of the panel and author of the DHR Overview Report is Steve Appleton. Steve trained as a social worker and specialised in mental health, working as an Approved Social Worker. During that time, he worked with victims of domestic abuse as part of his social work practice. He has held operational and strategic development posts in local authorities and the NHS. Before working independently, he was a senior manager for an English Strategic Health Authority in Thames Valley, Hampshire and the Isle of Wight with particular responsibility for mental health, learning disability, substance misuse and offender health.

20. Steve is entirely independent and has had no previous involvement with the subjects of the DHR. He has considerable experience in health and social care and has worked with a wide range of NHS organisations, local authorities and third sector agencies. He is a managing director of his own limited company, a specialist health and social care consultancy.

21. Steve has led reviews into a number of high profile serious untoward incidents particularly in relation to mental health homicide, safeguarding of vulnerable adults, investigations into professional misconduct by staff and has chaired a Serious Case Review into an infant homicide. He has chaired and written a number of DHRs for local authority community safety partnerships across the country. He has completed the DHR Chair training modules and retains an up to date knowledge of current legislation

22. Steve as an Independent Chair and author has never been employed by any of the agencies concerned with this review and has no personal connection to any of the people involved in the case.

Terms of Reference

23. Terms of Reference were developed and agreed. These were discussed by panel members, the independent chair and with family members. The Terms of Reference were as follows:

- Consider the period from 1 February 2015 to February 2020 (this is intended to cover the period from when the couple moved to Somerset) subject to any significant information emerging that prompts a review of any earlier or subsequent incidents or events that are relevant.

- Request Individual Management Reviews by each of the agencies defined in Section 9 of the Domestic Violence Crime and Victims Act (2004), and invite responses from any other relevant agencies or individuals identified through the process of the review.

- Seek the involvement of the family, employers, neighbours & friends to provide a robust analysis of the events. Taking account of the coroners' inquest in terms of timing and contact with the family.

- Aim to produce a report within six months of the DHR being commissioned which summarises the chronology of the events, including the actions of involved agencies, analysis and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.

- Consider how (and if knowledge of) all forms of domestic abuse (including the non-physical types) are understood by the local community at large – including family, friends and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control are also fully explored

- To discover if all relevant civil or criminal interventions were considered and/or used.

- Determine if there were any barriers Diane or her family/friends faced in both reporting domestic abuse and accessing services. This should also be explored:

    - Against the Equality Act 2010's protected characteristics.
    - In the context of the rural community in which Diane lived

- Consider what is 'good practice' for agencies to achieve in their response to domestic abuse in rural locations such as where Diane lived.

- Examine the events leading up to the incident, including a chronology of the events in question.

- Review the interventions, care and treatment and or support provided. Consider whether the work undertaken by services in this case was consistent with each organisation's professional standards and domestic abuse policy, procedures and protocols including Safeguarding Adults.

- Review the communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessment and management and the care and service delivery of all the agencies involved.

- Identify any care or service delivery issues, alongside factors that might have contributed to the incident.

- Examine how organisations adhered to their own local policies and procedures and ensure adherence to national good practice.

- Review documentation and recording of key information, including assessments, risk assessments, care plans and management plans.

- Examine whether services and agencies ensured the welfare of any adults at risk, whether services took account of the wishes and views of members of the family in decision making and how this was done and if thresholds for intervention were appropriately set and correctly applied in this case.

- Whether practices by all agencies were sensitive to the gender, age, disability, ethnic, cultural, linguistic and religious identity of both the individuals who are subjects of the review and whether any additional needs on the part of either were explored, shared appropriately and recorded.

- Whether organisations were subject to organisational change and if so, did it have any impact over the period covered by the DHR. Had it been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively?

24. This review is not an inquiry into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

Key findings and conclusions

25. Having reviewed and analysed the information contained within the IMRs and having considered the chronology of events and the information provided, the panel has drawn the following conclusions:

26. The contact between statutory agencies and Diane and Jeremy was very limited. They had not been engaged with any services or agencies in the period covered by the DHR in relation to domestic abuse matters. Their contact with agencies was largely routine, and in the case of primary and secondary care NHS services, the result of general health concerns.

27. The police responded appropriately in relation to Jeremy's drink driving offence. They paid necessary regard to his mental health and wellbeing and engaged the ASCC service to assess him.

28. The ASCC conducted a thorough assessment, paid regard to issues of consent and reached a clear decision about their actions and provided Jeremy with information about support services.

29. The agencies that had contact with Diane and Jeremy treated them with respect and their inputs were provided in line with relevant policy and guidance.

30. The conversations with Diane's partner, and friends revealed a pattern of behaviour by Jeremy towards her that could constitute coercion and control. This was characterised by him regularly belittling her verbally and using abusive language towards and about her.

31. This may point to a wider lack of awareness of domestic abuse among members of the public and unwillingness to report it. This could be for a variety of reasons, not least a wish not to be seen to be interfering in the private lives of others. It may also be that the nature of coercive control, although now gaining greater prominence, is not widely known about or understood by members of the wider public and thus by families of those who experience it.

32. There is evidence that Jeremy may have physically assaulted Diane by pushing her on more than one occasion. She did not report this to the police but did mention it to friends.

33. Diane clearly took the lead in running the couple's business. It was noted by the panel that she held the responsibility for the financial health of the business and for the couple personally. Some may interpret Jeremy's behaviour as economic abuse by making Diane responsible for the business and exploiting her economic resources by not contributing. It was the conclusion of the panel that there was insufficient evidence to reach such a definitive judgment, but it was recognised that there was a clear financial imbalance in the relationship that affected Diane directly.

34. There is no evidence that any agency in contact with Diane or Jeremy every enquired about issues relating to domestic abuse. This may be explained by there being no apparent evidence or reason to make any such enquiry. However, in the context of their respective sleep issues, this was not explored to understand if there were any emotional or other reasons that were impacting on Diane's ability to sleep. In the context of Jeremy, where he talked about issues in his relationship as well as other factors, these were not then used as means to undertake any further more detailed exploration or inquiry of whether there was any domestic abuse taking place in the relationship.

35. The issue of Jeremy's application for a firearms licence is pertinent to this DHR. The police made enquiries of the GP as part of the application process. A GP registrar rather than a more senior GP reviewed this. It is understood that this GP did not have direct contact with or wider knowledge of Jeremy but would have been under the supervision of a more senior GP.

36. The way in which decisions are made by GP's in responding to such enquiries is not subject to any recognised national framework that would infer any degree of consistency. In this case, the fact that Jeremy had displayed depressive symptoms and had a history of heavy drinking, both five years previously may have been relevant. However, the lack of clarity in the guidance about what level of mental health concerns might contribute to a decision not to recommend a person for such a licence, or how far back to go in a person's history was also a factor that led to challenges in understanding what information is and is not relevant should be included. More detailed guidance may have prompted better and more effective information sharing.

37. It is important to also recognise that GP's have to strike a fine balance in this decision making. They undertake the assessment and decision making in an autonomous way, without overarching national guidance, in the knowledge that their decision may have a significant impact on the person, possibly their livelihood and their wellbeing. In the same way decisions about revocation of a driving licence can have a similar impact, however, DVLA guidance provides a helpful framework for all professionals to follow.

38. In relation to the decision by the police to revoke his firearms licence and seize his guns was appropriate in line with relevant legislation.

39. The Firearms Act 1968 specifically states that a firearm certificate may be revoked if the holder is "of intemperate habits or unsound mind or is otherwise unfitted to be entrusted with a firearm". Furthermore, The College of Policing Authorised Professional Practice (APP) guidance on Firearms Licensing mandates that licenses are subject to continuous monitoring and risk assessment and will be revoked if there is a concern for safety. This is based on a professional judgement and will be authorised by the Licensing Bureau Manager (or deputy) who has delegated responsibility from the Chief Constable.

40. On the basis of the information provide the DHR panel has concluded that the process around the seizure of the guns was in line with this guidance. The police took quick and decisive action to seize Jeremy's guns to safeguard him and others.

41. Both Diane and Jeremy had a long history of gun ownership, and participation in country sports. Their use of guns was not regarded as a risk within their relationship with each other or with any other party.

42. Jeremy's firearm certificate showed his latest shotgun and firearms certificates had been revoked 11 days before he killed Diane. He had six previous shotgun/firearm certificates, which had been cancelled due to transferring out to a different police force area in around the year 2000.

43. The DHR panel has concluded that the matter of how the weapon Jeremy used to murder Diane was left in the house is not one that is directly in the scope of the review. The panel has however discussed the issue and noted that the police had no reason to suspect that there were any unlicensed, activated weapons at the property and as such, had no evidence or basis

upon which to conduct any further search of the property. They acted swiftly to revoke his forearms licence and the remove those licenced weapons, the panel also notes that Jeremy was co-operative during the seizure process.

44. Notwithstanding the conclusion that the process around gun seizure was conducted in accordance with national legislation and guidance the DHR panel has concluded that there are areas for improvement. Specifically this relates to the lack of immediate recording of the process on the NICHE system. This was only done retrospectively and although this was not an oversight, it has highlighted the fact that there is no requirement for such recording and the DHR panel concludes that this is an issue of practice that needs to be addressed. This is not just a matter for Somerset but nationally too.

45. This also applies to the use of BWV, which unless deemed evidential, is not routinely used or kept in the process of firearm seizure. The IMR concludes that this is a matter of procedural guidance that should be updated and the DHR panel concurs with this view.

46. Although the contact with agencies was limited, there was a lack of professional curiosity. This meant that where there were apparent clues about difficulties in the relationship described by Jeremy were never explored or probed with any depth of detail.

47. The information gleaned from Diane's partner and others has shown that Jeremy's alcohol use; history of depressive symptoms and low mood and behaviour towards Diane was on long standing. Although they expressed concerns between them, there was no indication that he would harm her or be a risk to her life.

48. The nature of the relationship between Jeremy's mental health and alcohol misuse was not adequately considered or addressed. The misuse of alcohol places individuals at greater levels of risk in relation to physical and mental health, their financial circumstances and their relationships, as such the Institute of Alcohol Studies suggests that it can increase an individual's overall risk and also in some cases their own vulnerability.

49. Research to indicate that alcoholism and drug abuse causes domestic violence is limited but that which exists indicates that among men who drink heavily, there is a higher rate of assaults resulting in injury.[1] Evidence

[1] Very Well Mind – international online research library accessed February 2021

suggests that alcohol use increases the chance and gravity of domestic violence, showing a direct correlation between the two. Because alcohol use affects cognitive and physical function, it reduces a person's self-control and lessens their ability to negotiate a non-violent resolution to conflicts.[2]

50. The DHR panel has concluded that the rurality of the property contributed to Jeremy's low mood after Diane left him and he had been arrested for drink driving. It contributed to his sense of isolation and impacted his ability to travel. The DHR panel notes this, not as an excuse for his actions, but to highlight the effect this isolation had on him and the part it played in his mental wellbeing.

51. The loss of Jeremy's driving licence also led to further isolation and the loss of his gun licence would have had an impact on his social and work life. The mental health team, who failed to inform the GP which meant that the GP could not support him, did not consider this.

52. The impact of Diane's death has had a lasting impact on her partner in Ireland and her friends, one of who was present when she was killed. This represents a significant trauma for them, her wider family and friends, and the panel again extends its condolences to them.

Lesson learnt

53. There is an apparent lack of national practice guidance relating to how GP's review and respond to applications for firearms licences. There is a variable practice in Somerset and it is likely that this extends nationally. The key lesson here is that without clear guidance, this variance of practice is likely to be maintained. This means that decision-making is left to individual practitioners and will be based largely on their knowledge of the specific person to whom the application applies. In some circumstances the GP may not have an in depth knowledge of the person and therefore increases the need for clear and detailed guidance.

54. Jeremy displayed behaviour towards Diane that could be characterised as coercive and controlling, this included the undermining and belittling language he often used towards her and about her to others. The DHR panel knows from the discussions with Diane's friend Jenny that she and other friends of the couple were aware of the difficulties between them and

[2] American Addiction Centers alcohol.org accessed February 2021

recognised the increasingly abusive nature of Jeremy's behaviour. Those friends often had frank exchanges with both Diane and Jeremy, going back 10 or 11 years and encouraged them to seek counselling support. Even when their relationship was tense neither of them could see themselves as being apart from one another. Jenny stated that Diane did not see herself as a victim and would often dismiss the concerns of Jenny and her other friends. She certainly had the control over the household, social events; business deals and the finances were firmly in her hands.

55. Unfortunately, as time went on it is possible that Jeremy found that the only way to feel in control was through the constant criticism and undermining, which was always worse when he was inebriated. Jenny said that friends did rally round to try and support Jeremy when Diane left, that he did try to live on his own, but he had always lived with a strong woman to support him. It was when Diane decided it was time to look after herself that led Jeremy to become confused and then resentful.

56. Jenny advised that she knew from a close male friend that during that last week or so, Jeremy veered from being maudlin and tearful to angry and vengeful. This person feels deep regret and guilt that he did not take Jeremy's statements when drunk more seriously. She stated that none of the couple's friends thought that he would become so disturbed as to kill Diane, only possibly himself.

57. This case demonstrates that coercive control may not always be recognised as such by the victim, or indeed their family, friends or professionals in contact with that victim. The lesson to be learnt is that work remains to be done to raise awareness of coercive control, encouragement to victims to recognise and report it, and for agencies to respond to it appropriately.

58. The DHR has revealed the limited nature of contact with agencies, and once again demonstrated that very often, domestic abuse can be largely hidden from view. It has also shows how it often requires a greater degree of professional curiosity to reveal it to those agencies that come into contact with victims but that in many circumstances this is difficult to achieve. This can be exacerbated in rural communities. A 2019 report from the National Rural Crime Network found that the more rural the setting, the higher the risk of harm, that abuse lasts on average 25% longer in the most rural areas

and support services are more scarce, less available and less visible.[3] It also found that rurality and isolation are deliberately used as weapons by abusers. These are important lessons in addressing domestic abuse in rural areas.

59. A further lesson learned is the vital role that friends and associates can play in providing information and insights about the relationships being reviewed. This is especially so in circumstances when agency involvement in limited, as it was in this case.

[3] Captive & controlled, domestic abuse in rural areas, NRCN 2019

Recommendations

The Domestic Homicide Review Panel made the following recommendations arising from the review. They were developed in direct response to the key findings and conclusions. The full Overview Report describes the linkages between the findings and recommendations in more detail.

- Recommendation One: Avon and Somerset Police implement their own recommendation relating to the standard operating procedure for the firearms seizure. In so doing they should liaise with the appropriate policing and justice bodies nationally to ensure that the lessons learned from this review contribute to national practice.

- Recommendation Two: Avon and Somerset Police should put in place a process to ensure that the NICHE system is used to record and flag individuals who have a firearms licence. The DHR panel notes that this is work in progress but recommend it is completed swiftly. Again the police should liaise with the appropriate policing and justice bodies national to ensure that the lessons learned from this review contribute to national practice.

- Recommendation Three: The Safer Somerset Partnership, in conjunction with the Avon and Somerset Police and the Clinical Commissioning Group should liaise with NHS England/Improvement, the Department for Health and Social Care and the Royal College of GPs to consider what national guidance might be put in place to ensure a more consistent approach to GPs responses to police enquiries about an individual's fitness to hold a firearms licence.

- Recommendation Four: Somerset NHS Foundation Trust should clarify with organisational partners when their ASCC would usually notify a GP when they have conducted an assessment of an individual. This might only be when a person is at risk of harm to themselves or others, but at present there is no clarity about this. This is an area of practice that needs to be improved.

- Recommendation Five: The Safer Somerset Partnership should undertake work to establish what particular domestic abuse issues might be affected by the rurality of part of their area. They should then use this information to inform their public awareness campaigns and their local training offer.