Domestic Homicide Review
Sandra/2014
Executive Summary

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Commissioned by:
Kent Community Safety Partnership
Medway Community Safety Partnership

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1. Introduction

This domestic homicide review (DHR) examines the circumstances surrounding the death of Sandra Dodds in Kent on 5 December 2014. She died as a result of acts committed by David Bryant, a man she had met while both were in-patients at a mental health facility in Kent, and with whom she living at the time of her death.

Following a trial of the facts at Maidstone Crown Court, the jury found that David had committed the acts that caused Sandra's death and he received a hospital order.

2. The Review Panel

The Review Panel consisted of an Independent Chairman and senior representatives of the organisations that had relevant contact with Sandra Dodds and/or David Bryant. It also included the Kent and Medway Domestic Abuse Coordinator and a senior member from each of Kent County Council and Medway Council Community Safety Teams. In addition, the manager of Choices, a Kent- based domestic abuse support organisation, sat on the Review Panel.

The members of the panel were:

Tim England	Medway Safer Communities
Christopher Gill	NHS England
Alison Gilmour	Kent & Medway Domestic Violence Coordinator
Tina Hughes	National Probation Service
Carol McKeough	Kent Adult Social Services
Sylvia Murray	Choices Domestic Abuse Support Service
Paul Pearce	Independent Chairman
Shafick Peerbux	Kent Community Safety
Andy Pritchard	Kent Police
Dr Hugh Series	Independent Consultant Old Age Psychiatrist commissioned by NHS England
Tracey Creaton	NHS West Kent Clinical Commissioning Group
Cecelia Wigley	Kent and Medway NHS and Social Care Partnership Trust

The Independent Chairman of the Review Panel is a retired senior police officer who has no association with any of the organisations represented on it. In particular, he did not serve with Kent Police. He has experience and knowledge of domestic abuse issues and legislation, and a clear understanding of the roles and responsibilities of those involved in the multi-agency approach to dealing with domestic abuse. He has a background in conducting reviews, investigations, and inspections, including disciplinary enquiries.

3. The Review Process

At an initial meeting of the Review Panel on 15 February 2015, the terms of reference were agreed. The involvement that agencies had with Sandra and/or David from 1 January 2010 to her death was considered and the following organisations were requested to provide Individual Management Reviews (IMRs):

- HM Prison Service (HM Prison Elmley, Kent)
- Kent and Medway NHS and Social Care Partnership Trust
- Kent Police
- National Probation Service
- West Kent Clinical Commissioning Group

IMRs include the following:

- a chronology of interaction with Sandra and David;
- what was done or agreed;
- whether internal procedures were followed; and
- conclusions and recommendations from the agency's perspective.

During the course of the review, information came to light that suggested the following organisation also had relevant contact and/or involvement with Sandra.

- West Kent Housing Association (Domestic Abuse Floating Support Service)

Full records of WKHA involvement were provided for the purposes of the review.

4. NHS Mental Health Homicide Investigation

NHS England undertakes an independent investigation when a patient, who has recently received care and treatment for a mental health disorder, commits a homicide. David Bryant fitted this criterion and a Mental Health Homicide Investigation (MHHI) was commissioned.

Following discussion between the Independent Chairman of the DHR and the Head of the regional NHS England MHHI Team, it was agreed that the terms of reference of the DHR and MHHI can be met combining the two and conducting a joint /DHR/MHHI. The MHHI Terms of Reference are set out in Appendix B to this report. The DHR will be the lead process and this Overview Report includes the information and analysis required to meet the MHHI terms of reference.

There will be a link from the MHHI section of the NHS England website to the DHR report.

In order to provide a review of the treatment that David received, NHS England has engaged an independent Consultant Old Age Psychiatrist, Dr Hugh Series DM, FRCPsych, LLM, MA, MB, BS. Dr Series is a member of the DHR Review Panel.

5. Terms of Reference for the DHR

Background

On 5 December 2014, Kent Police officers went to a flat, which was the home address of the victim, Sandra Dodds. They were responding to a 999 call made by the alleged perpetrator, David Bryant. When the officers arrived, David was there but refused them entry. They forced their way in and found the body of Sandra.

David was arrested for Sandra's murder, with which he was subsequently charged and remanded in custody. Sandra had suffered visible blunt and sharp force injuries but her death was the result of asphyxiation.

It was agreed by the Kent and Medway Domestic Homicide Review (DHR) Core Panel, at a meeting held on 9 January 2015, that the criteria for a DHR were met in accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004.

The agreement was ratified by the Chair of the Kent Community Safety Partnership (under a Kent & Medway CSP agreement to conduct DHRs jointly) and the Home Office has been informed.

The Purpose of the DHR

The purpose of this review is to:

i. Establish what lessons are to be learned from the death of Sandra Dodds in terms of the way in which professionals and organisations work individually and together to safeguard victims.

ii. Identify what those lessons are, both within and between agencies, how and within what timescales that they will be acted on, and what is expected to change as a result.

iii. Apply these lessons to service responses for all domestic abuse victims and their children through intra- and inter-agency working.

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

The Focus of the DHR

This review will establish whether any agency or agencies identified possible and/or actual domestic abuse that may have been relevant to the death of Sandra Dodds.

If such abuse took place and was not identified, the review will consider why not, and how such abuse can be identified in future cases.

If domestic abuse was identified, this review will focus on whether each agency's response to it was in accordance with its own and multi-agency policies, protocols, and procedures in existence at the time. In particular, if domestic abuse was identified, the review will examine the method used to identify risk and the action plan put in place to reduce that risk. This review will also take into account current legislation and good practice. The review will examine how the pattern of domestic abuse was recorded and what information was shared with other agencies.

The initial research does not suggest that Sandra was a victim of domestic abuse at the hands of David, prior to the incident resulting in her death. However, it is clear that both suffered from significant mental health conditions and that the events and involvement with agencies that each experienced in the years leading up to the homicide are likely to have had a bearing on it. For that reason, this DHR will have a particular focus on how both of them were treated and supported.

The review will examine in detail:

- The quality and scope of the health care treatment, care planning, and risk assessments for both Sandra and David.
- The appropriateness of Sandra's and David's treatment, care, and supervision in respect of the following aspects:
    - His assessed health needs.
    - His assessed risk of potential to harm himself and or others.
    - Any previous mental health history including drug and alcohol use.
    - Any previous forensic history including convictions.
    - The appropriateness on the intervention following self-referral to the West Kent Community Mental Health team on the 28 November 2014.
- The circumstances of Sandra and David meeting while in-patients on an acute ward, exploring any safeguarding issues that may have arisen.
- The learning from this incident and any recommendations to prevent such future incidents

DHR Methodology

Independent Management Reviews (IMRs) must be submitted using the templates current at the time of completion.

This review will be based on IMRs provided by the agencies that were notified of, or had contact with, Sandra and/or David in circumstances relevant to domestic abuse, or to factors that could have contributed towards domestic abuse, e.g. alcohol or substance misuse. Each IMR will be prepared by an appropriately skilled person who has not any direct involvement with Sandra or David, and who is not an immediate line manager of any staff whose actions are, or may be, subject to review within the IMR.

Each IMR will include a chronology, a genogram (if relevant), and analysis of the service provided by the agency submitting it. The IMR will highlight both good and poor practice, and will make recommendations for the individual agency and, where relevant, for multi-agency working. The IMR will include issues such as the resourcing/workload/supervision/support and training/experience of the professionals involved.

Each agency required to complete an IMR must include all information held about Sandra and/or David from 1 January 2010 to 5 December 2014. If any information relating to Sandra being a victim, or David being a perpetrator, of domestic abuse before 1 January 2010 comes to light, that should also be included in the IMR.

Information relevant to the homicide which is held by an agency required to complete an IMR must be included in full. This might include for example: previous incidents of violence (as a victim or perpetrator), alcohol/substance misuse, or mental health issues relating to Sandra and/or David. If the information is not relevant to the circumstances or nature of the homicide, a brief précis of it will be sufficient (e.g. in 2010, X was cautioned for an offence of shoplifting).

Any issues relevant to equality, such as disability, cultural and faith matters, should also be considered by the authors of IMRs. If none are relevant, a statement to the effect that these have been considered must be included.

When each agency that has been required to submit an IMR has done so in accordance with the agreed timescale, the IMRs will be considered at a meeting of the DHR Panel and an overview report will then be drafted by the Chair of the Panel. The draft overview report will be considered at a further meeting of the DHR Panel and a final, agreed version will be submitted to the Chair of Kent Community Safety Partnership.

Specific Issues to be Addressed

Specific issues that must be considered, and if relevant, addressed by each agency in their IMR are:

i. Were practitioners sensitive to the needs of Sandra and David, knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

ii. Did the agency have policies and procedures for the ACPO Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH) risk assessment and risk management for domestic abuse victims or perpetrators, and were those assessments correctly used in the case of Sandra and/or David (as applicable)? Did the agency have policies and procedures in place for dealing with concerns about domestic abuse? Were these assessment tools, procedures and policies professionally accepted as being effective? Was Sandra Dodds subject to a MARAC?

iii. Did the agency comply with information sharing protocols?

iv. What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

v. Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?

vi. Were procedures and practice sensitive to the ethnic, cultural, linguistic, religious and gender identity of Sandra and David (if these factors were relevant)? Was consideration of vulnerability and disability necessary (if relevant)?

vii. Were senior managers or other agencies and professionals involved at the appropriate points?

viii. Are there ways of working effectively that could be passed on to other organisations or individuals?

ix. Are there lessons to be learned from this case relating to the way in which an agency or agencies worked to safeguard Sandra and promote her welfare, or the way it identified, assessed, and managed the risks posed by David Bryant? Are any such lessons case specific, or do they apply to systems, processes and policies? Where can practice be improved? Are there implications for ways of working, training, management, and supervision, or for working in partnership with other agencies and resources?

x. How accessible were the services to Sandra and David (as applicable)?

xi. To what degree could the death of Sandra have been accurately predicted and prevented?

6. Terms of Reference for MHHI

Purpose of the investigation

This is a joint Domestic Homicide Review and Mental Health Homicide Investigation which involves the death of a woman in December 2014. The perpetrator and victim were both former patients of the Trust and this review will review their care and treatment.

Any health recommendations or outcomes of this investigation will be managed through corporate governance structures of NHS England, the lead clinical commissioning group, and the provider's formal Board sub-committees.

The purpose of the review is to identify whether there were any gaps or deficiencies in the care and treatment that David Bryant and Sandra Dodds received, which if addressed, could have resulted in the incident being predicted or prevented. The investigation process should also identify areas of best practice, opportunities for learning, and areas where improvements to services might be required which could help prevent similar incidents from occurring.

Terms of Reference

Review the engagement, assessment, treatment and care that David Bryant and Sandra Dodds received from Kent and Medway NHS Social Care and Partnership Trust: to include David Bryant's first contact with services from November 2010 until his discharge and Sandra Dodds' contact from November 2013 until her discharge.

Review the contact, information sharing and communication between the GP, Probation Services, and prison in-reach and Trust services in June 2014 and thereafter. Review the family's specific questions and ensure these have been fully addressed.

Assess if David Bryant's and Sandra Dodds' risks (to self and others) were fully understood and addressed, particularly the safeguarding concerns (vulnerable women and alleged child abduction).

Review if both David Bryant's and Sandra Dodds' care and treatment, including medication, was in line with best practice and national standards.

Review the Trust's internal investigation report and assess the adequacy of its findings, recommendations and implementation of the action plan and identify:

- If the investigation satisfied its own terms of reference.
- If all key issues and lessons have been identified and shared:
- Whether recommendations are appropriate, comprehensive and flow from the lessons learned.
- If progress was made against the action plan.
- If there are processes in place to embed any lessons learned.

Consider, having assessed the above, if this incident was predictable or preventable and comment on relevant issues that may warrant further investigation. Assess and review any contact and disclosures made to the family measured again the contractual and legal duty of candor.

Review and test the Trust governance and clinical commissioning group's governance, assurance and oversight of incidents against the new NHS England serious untoward incident framework.

Level of investigation

Type C: an investigation by a single investigator examining a single case (with peer reviewer).

Timescale

The investigation process has started, Individual Management Reviews from health are expected to be delivered within six weeks and the final report should be completed in line with the timescales of the Domestic Homicide Review.

Outputs

To offer independent input and review the Trust and primary care's Individual Management Reviews (IMR).

To contribute and offer expert advice and support to the Domestic Homicide Review panel.

To help produce a final report that can be published, that is easy to read and follow with a set of measurable and meaningful recommendations, having been legally and quality checked, proof read and shared and agreed with participating organisations and families (NHS England style guide to be followed).

To jointly make contact and engage with the family, initially sharing the terms of reference, ensuring their specific questions are included and examined, and provide ongoing input to the family.

To share the report at the end of the investigation, with the Trust and to meet the families to explain the findings of the investigation and to engage the clinical commissioning group and Domestic Homicide Panel with these meetings where appropriate.

To present the investigation to NHS England, lead clinical commissioning group, provider Board and to staff involved in the incident as required.

NHS England require the investigator to undertake an assurance follow up and review, six months after the report has been published, to independently assure NHS England and the commissioners that the report's recommendations have been fully implemented. The investigator should produce a short report f or NHS England, families and the commissioners and this may be made public.

Key:

Type A: a wide-ranging investigation by a panel examining a single case.

Type B: an investigation by a team examining a single case.

Type C: an investigation by a single investigator examining a single case (with peer reviewer).

7. Key issues arising from the Domestic Homicide Review

Sandra had suffered from depression for some years prior to her death but her mental health problems became significant in late 2013. David had significant mental health issues for some years prior to Sandra's death and had spent many months as an inpatient at mental health facilities. He had attempted suicide on at least three occasions during the period covered by this review and spent nearly two years in prison as a result of setting fires in a flat he was living in.

Sandra met David while both were inpatients at a mental health facility in Kent and they formed a close relationship after they were discharged. She allowed him to move into her flat, where they were living at the time of her death.

Following his release from prison, all but one social housing provider refused to provide accommodation for David. One provider offered him a flat but agreed with him that it was unsuitable. The combination of his mental health problems and the offence for which he was imprisoned caused housing providers to judge him as an unacceptable risk. He would have known this when discharged from the inpatient facility where he met Sandra and this may have initially encouraged him to seek accommodation with her or to accept her offer of help in that regard.

It is not known what events led to David killing Sandra: he had no history of being a domestic abuse perpetrator and neither agencies nor Sandra's family were aware of any domestic disputes between them.

8. Conclusions, Lessons Learned and Recommendations from the Review

Conclusions

Sandra and David met while they were inpatients in Ward A at Priority House. Within four months of their discharge they were living together at Sandra's flat. There is nothing to suggest that they were more than social acquaintances while they were at Priority House. There are no grounds for criticising KMPT's policies and procedures or the actions of any of its staff in relation to the two meeting and subsequently forming a relationship.

There is no evidence or information available to the Review Panel that Sandra was a victim of domestic abuse at the hands of David, prior to the event that led to her death. Similarly, there is no evidence or information to suggest that David had been a domestic abuse perpetrator prior to the actions which caused Sandra's death.

The Review Panel considered but discounted the likelihood that David formed a relationship with Sandra simply because he faced the prospect of being homeless after his discharge from Priority House. He bought her presents, went on holiday with her and helped her improve her flat, which indicated that his feelings for her went beyond regarding her as a means of keeping a roof over his head.

David, who had a conviction for arson, found it very difficult to get social accommodation once providers became aware of it; this was the case despite his vulnerability, which was due to his mental health condition. There is no evidence of multi-agency discussion about David's accommodation issues, beyond positive attempts by his probation officers to engage with housing providers.

There are also statements from accommodation providers that indicate David's mental health was a factor in not being willing to house him. This demonstrates how mental health conditions are still stigmatised in a way that physical health conditions are not.

A prison officer accompanying David to an Accident & Emergency Department, on his release from HMP Elmley, was an example of good practice. There was no duty placed on HMP Elmley to do this and, although David was free to do as he chose, it probably resulted in him getting immediate secondary mental health treatment after his release.

In addition, Oxleas NHS Trust liaised regularly with KMPT prior to David's release, so the latter would have known of his mental health history and treatment while in prison. This was a strong example of good practice.

Historically, it is possible that David's mental health condition and his homelessness could have resulted in his remaining in an institution indefinitely, particularly following the arson. Had this been the case he may not have met Sandra.

Mental health treatment is now focused on providing services in the community; when a patient is admitted to hospital every effort is made to return them to the community as soon as possible, having regard to the patient's health and safety and that of others. The treatment that David received was appropriate to his condition but it relied on him taking his prescribed medication, which can be difficult to manage when patients live in the community.

The use of Community Treatment Orders (CTO) is a way of attempting to ensure that patients with mental health conditions continue with treatment (including taking medication where appropriate) when they have been discharged into the community. This should be considered prior to every discharge from detention under Section 3 of the Mental Health Act 1983. although in this case it is not clear that David's condition would have met the criteria for a CTO.

There are no significant acts or omissions by agencies with whom either Sandra or David had contact during the period covered by this DHR that if they had not been made would have prevented her death. No one could have predicted that David would kill Sandra.

Lessons Learned

This DHR does not identify any lessons that relate specifically to domestic abuse or the prevention of domestic homicides. This is primarily because Sandra was not a victim of domestic abuse during the period covered by the review, nor was David a perpetrator. The only incidence of domestic abuse was the act that led to Sandra's death.

The two lessons learned in relation to mental healthcare each cover post patient - discharge actions: the need to decide the responsibility for further care in a timely manner and establishing a protocol for requesting police to visit patients who have been discharged.

Four recommendations have been made arising out of the information that has been provided by agencies that had involvement with Sandra and/or David, but these are not directly related to the circumstances of Sandra's death.

Recommendations

The Review Panel makes the following recommendations from this DHR:

	Recommendation	Organisation
1.	KMPT should review existing policies relating to inpatient discharge in order to ensure that in every case, whether by self-discharge or not, the responsibility for further care is decided within 24 hours of the unexpected absence of a patient from a ward. This should apply whether a patient is unexpectedly absent without leave or has discharged him- or herself.	KMPT
2.	In order to support inter-agency working, KMPT must include a section in their inpatient discharge policy that sets out the criteria for requesting Kent Police attendance when visiting patients after discharge. KMPT must consult Kent Police when drafting this section.	KMPT
3.	In order support to support joint agency working with KMPT, Kent Police must ensure that officers and staff understand the circumstances in which they should make referrals of people they believe are suffering from mental health conditions to KMPT and that the emphasis is on ensuring that the person gets the support they need from the appropriate agency.	Kent Police
4.	In order to ensure that the Prison Intelligence database is accurate, HMP Elmey must ensure that they make appropriate enquiries to ensure that the release address they record for prisoners is accurate.	HMP Elmley