

**Kent & Medway
Domestic Homicide Review**

Executive Summary

Jason/2016

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**Commissioned by:
Kent Community Safety Partnership
Medway Community Safety Partnership**

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1. The Review Process

- 1.1 This summary outlines the process undertaken by the Domestic Homicide Review (DHR) panel in reviewing the homicide of Jason Davis who lived in Kent.
- 1.2 The following pseudonyms have been in used in this review for the victim and perpetrator to protect their identities and those of their family members:
- | | |
|-------------|---------------|
| Victim | Jason Davis |
| Perpetrator | Michael Lyons |
- 1.3 Jason was a white British man aged 51 years at the time of his death. Michael was a white British man aged 38 years at that time.
- 1.4 Criminal proceedings were completed on 23 January 2017 and Michael was sentenced to 10 years imprisonment, having pleaded guilty to Jason's manslaughter.
- 1.5 The DHR Core Panel met on 27 June 2016 and agreed that the criteria for a DHR were met. The Chair of the Kent Community Safety Partnership was informed, and he made the formal decision that a DHR would be conducted. All agencies that potentially had contact with Jason and/or Michael prior to Jason's death were contacted and asked to confirm whether they had contact with them.
- 1.6 Those agencies that confirmed contact with the Jason and/or Michael were asked to secure their files.
- 1.7 A glossary of abbreviations and acronyms is included as an [Appendix](#) to this Executive Summary.

2. Contributing Organisations

- 2.1 Each of the following organisations completed an Independent Management Report (IMR) for this DHR:
- Kent Police
 - Kent County Council Adult Services
 - Town A Clinical Commissioning Group
 - Kent & Medway NHS and Social Care Partnership Trust
 - Kent Community Health NHS Foundation Trust
 - East Kent Hospitals University NHS Foundation Trust
 - South East Coast Ambulance Service NHS Foundation Trust
- 2.2 The contact that Kent Community Health NHS Foundation Trust had with Jason and Michael was not relevant to this DHR and is not included in this report.

- 2.3 IMR authors are staff from the respective agencies but have had no contact with either Jason or Michael.
- 2.4 In addition to IMRs, the Independent Chairman interviewed representatives of the following agencies and prepared a written report on each for the Review panel:
- Oasis Domestic Abuse Service
 - Town A Borough Council - Housing Department
 - Victim Support
- 2.5 The National Probation Service, which was not involved with Jason or Michael during the period covered by this DHR, provided an extensive chronology of earlier involvement. This provided useful background information.
- 2.6 This DHR is the first to be commissioned in Kent and Medway in which the victim and perpetrator were of the same sex. It is also the first in which the victim had been referred to the Multi-Agency Risk Assessment Conference (MARAC).

3. Review Panel Members

- 3.1 The Review Panel was made up of an Independent Chairman and senior representatives of organisations that had relevant contact with Jason and/or Michael. It also included a senior member of Kent County Council Community Safety Team.
- 3.2 The members of the panel were:
- | | |
|--------------------|--|
| Wendy Bennett | Town A Clinical Commissioning Group |
| Deborah Cartwright | Oasis Domestic Abuse Service |
| Angie Chapman | Kent Police |
| Tina Hughes | National Probation Service |
| Carol McKeough | Kent County Council Adult Social Services |
| David Naylor | Victim Support |
| Paul Pearce | Independent Chairman |
| Shafick Peerbux | Kent County Council Community Safety |
| Vikki Perry | Town A Borough Council, Communities & Housing Department |
| Cecelia Wigley | Kent and Medway NHS & Social Care Partnership Trust |
- 3.3 Panel members hold senior positions in their organisations and have not had contact or involvement with Jason or Michael. They met on three occasions during the DHR.

4. Independent Chairman and Author

- 4.1 The Independent Chairman and author of this overview report is a retired senior police officer who has no association with any of the organisations represented on the panel and who has not worked in Kent. He has experience and knowledge of domestic abuse issues and legislation, and an understanding of the roles and responsibilities of those involved in the multi-organisation approach to dealing with domestic abuse.
- 4.2 The Independent Chairman has a background in conducting reviews (including Serious Case and Safeguarding Reviews), investigations, inquiries and inspections. He has carried out senior level disciplinary investigations and presented at tribunal. He has completed the Home Office online training on DHRs, including the additional modules on chairing reviews and producing overview reports.

5. Terms of Reference

These terms of reference were agreed by the DHR Panel following their meeting on 29 July 2016.

5.1 Background

On 17 May 2016, an ambulance crew went to a flat in Town A, Kent, which was the home address of the victim, Jason Davis, who lived there alone. They found that Jason was dead and that he had suffered head injuries. Police were called and a murder investigation began.

Michael Lyons, who lived in Town A, was arrested on suspicion of Jason's murder. Michael was charged subsequently with this and was remanded in custody.

In accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004, a Kent and Medway Domestic Homicide Review (DHR) Core Panel meeting was held on 27 June 2016. It agreed that the criteria for a DHR had been met and on 7 July, the Chair of the Kent Community Safety Partnership (CSP) confirmed that a DHR would be conducted. (under a Kent & Medway CSP agreement to conduct DHRs jointly) and the Home Office has been informed.

5.2 The Purpose of a DHR

The purpose of this review is to:

- i. Establish what lessons are to be learned from the death of Jason Davis 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 organisations, how and within what timescales that they will be acted on, and what is expected to change.
- iii. Apply these lessons to service responses for all domestic abuse victims and their children through intra and inter-organisation working.
- iv. Prevent domestic abuse homicide and improve service responses for all domestic abuse victims and their children through improved intra and inter-organisation working.

5.3 The Focus of the DHR

This review will establish whether any organisation or organisations identified possible and/or actual domestic abuse that may have been relevant to the death of Jason Davis.

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 DHR will focus on whether each organisation's response to it was in accordance with its own and multi-organisation policies, protocols and procedures in existence at the time. 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 organisations.

The subjects of this review are the victim Jason Davis and the alleged perpetrator Michael Lyons.

5.4 DHR Methodology

The DHR will be based on information gathered from the Independent Management Reports (IMRs), chronologies and reports submitted by, and interviews with, organisations identified as having had contact with Jason and/or Michael in circumstances relevant to domestic abuse, or to factors that could have contributed towards domestic abuse, e.g. alcohol or substance misuse. The DHR Panel will decide the most appropriate method for gathering information from each organisation.

IMRs and chronologies must be submitted using the templates current at the time of completion. Reports will be submitted as free text documents. Interviews will be conducted by the Independent Chairman.

IMRs and reports will be prepared by an appropriately skilled person who has not had any direct involvement with Jason or Michael, 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 and analysis of the service provided by the organisation submitting it. The IMR will highlight both good and poor practice, and will make recommendations for the individual organisation and, where relevant, for multi-organisation working. The IMR will include issues such as the resourcing/workload/ supervision/support and training/experience of the professionals involved.

Each organisation required to complete an IMR must include all information held about Jason or Michael from 1 January 2012 to 17 May 2016. If any information relating to Jason being a victim, or Michael being a perpetrator, of domestic abuse before 1 January 2016 becomes known, that should also be included in the IMR.

Information held by an organisation that has been required to complete an IMR, which is relevant to the homicide, 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 Jason and/or Michael. 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 2012, X was cautioned for an offence of shoplifting).

Any issues relevant to equality, for example disability, sexual orientation, cultural and/or faith 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 organisation that has been required to submit an IMR does 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 Independent Chairman. 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 CSP.

5.5 Specific Issues to be Addressed

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

- i. Were practitioners sensitive to the needs of Jason and Michael, 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 organisation have policies and procedures for the 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 Jason and/or Michael (as applicable)? Did the organisation 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?
- iii. Did the organisation 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, sexual orientation and gender identity of Jason or Michael (if these factors were relevant)? Was consideration of vulnerability and disability necessary (if relevant)?
- vii. Were senior managers or other organisations 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 organisation or organisations worked to safeguard Jason and promote his welfare, or the way it identified, assessed and managed the risks posed by Michael Lyons? 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, working in partnership with other organisations and resources?

- x. How accessible were the services to Jason and Michael (as applicable)?
- xi. Was the referral of Jason to the Multi-Organisation Risk Assessment Conference (MARAC) managed effectively?
- xii. To what degree could the death of Jason have been accurately predicted and prevented?

6. Summary Chronology

- 6.1 Jason and Michael lived in Town A, Kent. Both were alcoholics. They had a single intimate encounter in 2010, following which Jason invariably referred to Michael as his friend. Jason was 51 years old at the time of his death; Michael was then 38 years old.
- 6.2 Michael pleaded guilty to Jason's manslaughter and was sentenced to 10 years imprisonment.
- 6.3 Jason was living with his mother until her death in 2013. Following this, he lived alone in a council-owned flat. It was during the period from his mother's death until his own that Jason was subjected to assaults and sustained harassment, coercion and control by Michael. Jason had a lot of involvement with statutory organisations during this time, including the police, social services, the ambulance service, his GP and the local acute hospital.
- 6.4 Michael therefore had a history as a domestic abuse perpetrator before the period covered by this DHR. Three of his four previous convictions related to violent offences committed against previous partners.
- 6.5 Jason disclosed his intimate encounter with Michael to Kent Police about six months after it happened. Because of this, the force recorded the incident they were dealing with at the time as domestic abuse. Other organisations would not have known about this until the last year of Jason's life. What was clear, was that Jason was being subjected to abuse by a friend, he was too frightened of reprisals to report assaults to the police and he was vulnerable. South East Coast Ambulance Service (SECamb) made three safeguarding alerts to Kent County Council Adult Services (KCCAS) and they tried to support Jason. However, had all the agencies who were involved with him during that time been brought together, a clearer picture of his vulnerability would have emerged.
- 6.6 In June 2015, following the second safeguarding alert from SECamb, KCCAS referred Jason to an Independent Domestic Adviser (IDVA) service run by Oasis, a domestic abuse support charity. An IDVA correctly assessed Jason as being at high risk of domestic abuse and referred him to the Town A MARAC.

- 6.7 At the MARAC meeting in August 2015, an action was allocated to Kent Police to conduct a joint visit to Jason with an IDVA. This action was not implemented. From then until his death, opportunities were missed to re-refer Jason to the MARAC, apparently because of a lack of understanding of the MARAC repeat referral criteria.

7. Conclusions

- 7.1 Jason suffered harassment, control and coercion, and physical assaults by Michael for about two and a half years. The domestic abuse he suffered led to his death.
- 7.2 In 2010, when attending an incident in which Jason was the victim and Michael the perpetrator, Kent Police classified it as domestic abuse because Jason told them that he had had a one-night stand with Michael six months previously. They did this because the definition of domestic abuse in place at that time referred to 'intimate partners' and they decided that this applied to Jason and Michael. On that basis, it is appropriate to consider any subsequent abuse against Jason by Michael as domestic abuse, even though other organisations may not have been aware of it fitting the definition.
- 7.3 Although Kent Police correctly identified Jason as a victim of domestic abuse in 2010, between then and his death, there were occasions when he was not dealt with as such. On more than one occasion, they recorded that incidents were not domestic abuse.
- 7.4 The term 'intimate partners' is used in the cross-government, non-statutory definition of domestic abuse – the term is not defined. The term 'personally connected' is used in the offence of controlling or coercive behaviour (Section 76 of the Serious Crime Act 2015) and is defined. The offence and the definition of 'personally connected' are set out in Appendix D.
- 7.5 The relationship that Jason and Michael had does not meet the definition of 'personally connected'. Thus, Michael did not commit the S.76 offence, even though the abuse he was inflicting on Jason met the definition of domestic abuse, and his behaviour met the definition of 'controlling or coercive'. The Home Office must ensure that the definition of 'personally connected' in the Statutory Guidance for Section 76 of the Serious Crime Act 2015 is changed to ensure that all victims of domestic abuse are protected. **(Recommendation 20)**
- 7.6 In June 2015, following the second safeguarding alert by SECamb, KCCAS asked Kent Police for any information they had about Jason. When KCCAS contacted Jason, he gave information that signalled that he might be a victim of domestic abuse. Both the referral by SECamb to KCCAS and the subsequent

referral by the latter to the Independent Domestic Violence Adviser (IDVA) service were examples of good practice.

- 7.7 When Jason spoke to the IDVA dealing with his case in June 2015, he described Michael as his ex-boyfriend and referred to their previous relationship. The IDVA assessed Jason as being a high risk domestic abuse victim. This was an appropriate grading based on a DASH risk assessment, which included the IDVA's professional judgement. The IDVA correctly referred Jason to the MARAC.
- 7.8 There was a single action relating to Jason's case recorded on the MARAC action list. This action was assigned to Kent Police. The decision by them not to implement it, or to at least explore ways of giving Jason the confidence to report criminal offences to the police, was significant. It meant that he received no support resulting from his referral to the MARAC. Although the decision not to implement the action was discussed with the IDVA, it was not shared with other members of the MARAC.
- 7.9 Following the MARAC meeting, Jason was the victim of domestic abuse that met the criteria for a repeat referral. Recommendations have been made for the organisations that failed to recognise this.
- 7.10 Even had Jason not had the intimate encounter with Michael, which meant he was the victim of domestic abuse, he was an adult who needed care and support. Following his death, it seems likely that his case meets the criteria set out in S.44 of the Care Act 2014 for conducting a Safeguarding Adults Review. For that reason, the chair of the Kent and Medway Community Safety Partnership should share this report with the chair of the Kent and Medway Safeguarding Adults Board. **(Recommendation 21)**
- 7.11 A significant factor in Jason's death was that he and Michael had alcohol problems. During Michael's daily visit to Jason's flat they would both drink heavily. Michael had relatively little involvement with organisations during the period covered by this DHR and his problem drinking was not identified. Jason had a lot of contact with organisations and while all identified his problem drinking, very little was done to help him in this regard.
- 7.12 The only efforts made were by KMPT, who repeatedly made attempts to encourage Jason to engage with Turning Point, all of which were unsuccessful. Alcohol Concern, the national charity established to help reduce the problems that can be caused by alcohol, identified in their Blue Light project that about 85% of problem drinkers are not attempting to change their drinking habits. As well as the harm they suffer, this can put a significant drain on the resources of the police, the NHS and social services.

- 7.13 Charities such as Turning Point have limited funding and work hard to cope with providing support to those willing to engage with their treatment service. It is unrealistic to expect them to be able to put significant resource into encouraging those who are not.
- 7.14 For statutory organisations there will be an initial additional cost in working to change the attitude of treatment resistant drinkers to the extent that they engage with treatment services. However, success will see savings in the future and more importantly might reduce the likelihood of tragic outcomes such as Jason's case. Statutory organisations would do well to consider whether the approach set out in the Blue Light project manual might bring benefits that make the initial investment worthwhile.
- 7.15 Careful consideration has been given during this DHR to whether the care and support given to Jason as a domestic abuse victim were influenced by his gender and/or because the abuse he suffered followed an intimate same-sex relationship.
- 7.16 The Kent and Medway Domestic Abuse Strategy 2013-2016 recognises that research suggests domestic violence occurs in all sections of society irrespective including of, among other factors, gender and sexual orientation. When discussing underreporting of domestic abuse, the strategy quotes Home Office figures, which estimate the number of likely female victims of domestic abuse. However, the strategy acknowledges that about 18% of domestic incidents reported to Kent Police have a male victim. There are no figures for domestic abuse incidents in same-sex relationships.
- 7.17 There is no evidence that the care and support given to Jason, or in some cases the lack of it, was due either to his gender or sexual orientation. During the research for this DHR, the support provided to male domestic abuse victims and those in same sex relationships was discussed with the Chief Executive of Oasis Domestic Abuse Service. About 5% of the domestic abuse victims the organisation deals with are men. Much work has been done to encourage men who have been victims of domestic abuse to report it.
- 7.18 Efforts have also been made to encourage homosexual men to report domestic abuse. Oasis have also attended the Thanet Pride event and the feedback that they received was that homosexual men need to feel that they have a safe space where people understand their specific issues - they look for the rainbow flag.
- 7.19 One of the largest and best-known support agencies for victims of domestic abuse in same-sex relationships, Broken Rainbow, closed in June 2016. Galop is a London-based hotline that provides nationwide support for LGBT victims of domestic abuse, but it is disappointing that given the feedback provided to Oasis,

there are no Kent-based organisations offering this specific support. Jason did engage with Oasis initially, as he did to an extent with KCCAS, but he may have been prepared to receive advice and support more readily from an organisation that understood his personal situation better.

8. Lessons To Be Learned

8.1 Domestic abuse victims may need care and support and meet the criteria set out in Section 42 of the Care Act 2014.

8.1.1 Understanding of the relevant sections of the Care Act 2014 can be important in domestic abuse cases. Dependent on the circumstances, it may be more appropriate to hold a multi-agency safeguarding planning meeting involving the appropriate agencies than to use the MARAC process. Alternatively, an action from the MARAC meeting might be to suggest such a planning meeting is the best way forward.

8.1.2 The need to safeguard domestic abuse victims is paramount and a flexible approach to the best means to achieve this is important.

8.2 The administrative processes supporting MARAC meetings are important in ensuring that high risk domestic abuse victims receive the service and support they need.

8.2.1 This case highlights how important accurate minute taking and recording of actions is as part of the MARAC process. It is not about bureaucracy; it ensures that all agencies are clear about what has been agreed and what is required of them. It also provides a clear record of previous considerations and actions in the event of a repeat referral.

8.3 There needs to be an emphasis placed on ensuring an understanding of the criterion for repeat referrals to MARACs in Kent and Medway.

8.3.1 The criterion is clear and appropriate but there is evidence that it is not being applied.

8.4 Organisations should not rely on email as the sole means of communication when referring safeguarding issues between internal departments or to other organisations.

8.4.1 An email provides a written record of a referral but there is no guarantee it will reach the right destination, or that the email address it is sent to is regularly monitored. Consideration should always be given to making the first referral verbally, to ensure the person receiving is someone who can ensure that it is actioned in a timely manner. Confirmation of the right email address for a

follow up confirmation can then be made.

8.5 There is a currently a lack of support specific to LGBT victims of domestic abuse across Kent and Medway.

8.5.1 It is not clear whether Jason would have engaged more willingly with an organisation that could empathise with his personal situation but there is a service gap in this area.

9. Recommendations

9.1 The Review Panel makes the following recommendations from this DHR:

	Recommendation	Organisation
1.	In cases that have been referred to MARAC, where there is information that the victim is too frightened to report domestic abuse to them, Kent Police must actively seek to engage with the victim.	Kent Police
2.	Kent Police must ensure that Public Protection Unit supervisors have considered all the available information before making decisions about MARAC actions and that they record their rationale.	Kent Police
3.	Kent Police must ensure that officers working in Public Protection Units have an in depth understanding of how best to provide support to victims of domestic abuse.	Kent Police
4.	Kent Police must ensure that an understanding of the MARAC repeat referral criterion forms part of their domestic abuse training programme.	Kent Police
5.	In its domestic abuse training programme, Kent Police must highlight that once two people have had an intimate relationship, it will be domestic abuse if one inflicts upon the other, behaviour that is mentioned in the definition of domestic abuse, regardless of the passage of time.	Kent Police

6.	Kent Police must ensure that police officers and police staff who may have contact with vulnerable people understand when safeguarding alerts should be made to Kent County Council Adult Services (KCCAS).	Kent Police
7.	KCCAS must ensure that staff who might work on cases involving domestic abuse are aware of the criterion for the repeat referral of a case to the MARAC.	KCCAS
8.	KCCAS must ensure that they have a robust system for communicating safeguarding information within their organisation and to other organisations.	KCCAS
9.	Clinical Commissioning Groups (CCGs) should ensure that GPs are aware of the MARAC process, including the criterion for referring repeat cases.	CCGs in Kent and Medway
10.	NHS England should ensure that the contractor responsible for storing archived GP records is aware of the requirement to provide the records in a timely manner when requested for a DHR.	NHS England
11.	CCGs in Kent and Medway should provide guidance to GPs about providing records when requested as part of a DHR, taking account of Section 10 of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews.	CCGs in Kent and Medway
12.	Town A Borough Council should ensure that their Housing Area Managers are familiar with the Kent and Medway MARAC Operating Protocol and Guidelines.	Town A Borough Council
13.	Kent Domestic Abuse Consortium (KDAC) should remind IDVAs when attempts to contact victims, whether successful or not, cannot be recorded contemporaneously on the database, full and accurate records of the time and content of calls should be made and added to the database at the earliest opportunity.	KDAC

14.	KDAC members must agree a process that ensures the IDVA who has the greatest knowledge of a case attends the MARAC meeting when it is discussed.	KDAC
15.	KDAC must ensure that before closing a case that was initially referred to a member organisation by another agency, the referring organisation should be asked if they have any further relevant information.	KDAC
16.	Kent and Medway Domestic Abuse Strategy Group (KMDASG) should consider publishing the Kent and Medway MARAC Operating Protocol and Guidelines online.	KMDASG
17.	KMDASG should take the lead in encouraging appropriate agencies to become involved in chairing MARAC meetings.	KMDASG
18.	KMDASG should agree a process that ensures minutes are taken at all MARAC meetings and include this in the Kent and Medway MARAC Operating Protocol and Guidelines.	KMDASG
19.	KMDASG must establish a process that ensures all MARAC actions from the previous meeting have either been implemented or if not, the reasons why. A record must be kept of the results.	KMDASG
20.	The Home Office should ensure that the definition of 'personally connected' in the Statutory Guidance for Section 76 of the Serious Crime Act 2015 is changed to ensure that all victims of domestic abuse are protected.	The Home Office
21.	The chair of the Kent Community Safety Partnership (CSP) should share this report with the chair of the Kent and Medway Safeguarding Adults Board.	Kent CSP

GLOSSARY

Abbreviation/Acronym	Expansion
CCG	Clinical Commissioning Group
CSP	Community Safety Partnership
DASH	Domestic Abuse, Stalking and Harassment (Risk Assessment)
DHR	Domestic Homicide Review
DV	Domestic Violence
IMR	Independent Management Report
KDAC	Kent Domestic Abuse Consortium
KMPT	Kent & Medway NHS & Social Care Partnership Trust
KCCAS	Kent County Council Adult Services
KCHFT	Kent Community Health NHS Foundation Trust
KMDASG	Kent and Medway Domestic Abuse Steering Group
LGBT	Lesbian, Gay, Bisexual and Transgender
MARAC	Multi-Agency Risk Assessment Conference
NHS	National Health Service
SECAmb	South East Coast Ambulance Service NHS Foundation Trust