KENT & MEDWAY

DOMESTIC HOMICIDE REVIEW

Roger/2015

Executive Summary

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Commissioned by:
Kent Community Safety Partnership
Medway Community Safety Partnership

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EXECUTIVE SUMMARY

1. INTRODUCTION

This Domestic Homicide Review (DHR) examines the circumstances surrounding the death of Roger Hills in Town A, Kent on 19 May 2015. He died of multiple stab wounds inflicted by his younger son, Stephen, at the family home. Stephen was convicted of his father's manslaughter and of causing grievous bodily harm with intent to his brother, Graham. He was sentenced to 18 years and 9 years imprisonment respectively for these crimes, to be served concurrently.

2. THE REVIEW PROCESS

This Review began on 7 July 2015, following the decision by Kent Community Safety Partnership (CSP) that the case met the criteria for conducting a DHR.

The DHR Panel agreed that the Review should consider the period between 1 January 2008 and the date of Roger's death.

The following organisations were requested to provide Individual Management Reviews (IMRs):

- Kent Police
- National Probation Service (NPS)
- West Kent Clinical Commissioning Group (WKCCG)
- Kent & Medway NHS and Social Care Partnership Trust (KMPT)

IMRs include the following:

- a chronology of interaction with Roger and Stephen;
- 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 organisations also had some involvement with Roger and/or Stephen and they provided information to the DHR:

- Circle Housing Russet (CHR)
- Tonbridge & Malling Borough Council (Housing Department)

The Independent Chairman wrote to family members on a number of occasions to offer them the opportunity to be part of the DHR process. No replies were received.

3. THE REVIEW PANEL

The Review Panel was made up of an Independent Chairman and senior representatives of the organisations that had relevant contact with Roger, Stephen or Graham Hills. It also included the Kent & Medway Domestic Abuse Co-ordinator and a senior member of Kent County Council Community Safety Team. In addition, a representative from Oasis Domestic Abuse Service, a Kent-based domestic abuse support organisation, sat on the Review Panel.

The members of the panel were:

Deborah Cartwright	Oasis Domestic Abuse Service
Tracey Creaton	West Kent Clinical Commissioning Group
Alison Gilmour	Kent & Medway Domestic Abuse Co-ordinator
Pam Flight	Kent Police
Tina Hughes	National Probation Service
Carol McKeough	Kent County Council Adult Social Services
Paul Pearce	Independent Chairman
Shafick Peerbux	Kent Community Safety
Cecelia Wigley	Kent and Medway NHS & Social Care Partnership Trust

The Independent Chairman of the 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 an 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 and investigations.

The DHR has been anonymised and all the personal names contained within it, with the exception of members of the DHR Panel, are pseudonyms.

4. TERMS OF REFERENCE

These terms of reference were agreed by the DHR Panel following their meeting on 4 August 2015.

Background

On 19 May 2015, police officers went to a house in Town A, Kent, which was the home address of the victim, Roger Hills, and the perpetrator, his adult son Stephen Hills. They found that the victim had been stabbed by the perpetrator and that the second adult son of the victim, Graham Hills, had also been stabbed by the perpetrator. As a result of the stabbings, Roger Hills died and Graham Hills suffered serious injuries.

Stephen was arrested for Roger's murder and for causing grievous bodily harm to Graham. He was subsequently charged with these crimes and 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 13 July 2015. It confirmed that the criteria for a DHR had been met.

That agreement has been 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 a DHR

The purpose of this review is to:

i. Establish what lessons are to be learned from the death of Roger Hills 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 Roger Hills.

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.

In addition to the homicide victim (Roger Hills) and perpetrator (Stephen Hills), Graham Hills will be a subject of this review in order to ensure that any agency contacts with him, which might have had a bearing on the circumstances of the homicide, are considered.

DHR Methodology

Independent Management Reports (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, Roger, Graham or Stephen 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 had any direct involvement with Roger, Graham or Stephen, 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 Roger, Graham or Stephen from 1 January 2008 to 19 May 2015. If any information relating to Roger or Graham being victims, or Stephen being a perpetrator, of domestic abuse before 1 January 2008 comes to light, that should also be included in the IMR.

Information held by an agency 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 Roger and/or Stephen. 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, for example 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 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 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 CSP.

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 Roger, Graham and Stephen, 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 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 Roger, Stephen or Graham (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?

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 Roger, Graham or Stephen (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 Roger and promote his welfare,

or the way it identified, assessed and managed the risks posed by Stephen Hills? 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 agencies and resources?

x. How accessible were the services to Roger, Graham and Stephen (as applicable)?

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

5. KEY ISSUES ARISING FROM THE REVIEW

Roger and his wife, Diane, lived in Town A, Kent. They had been married for many years and had four children together: two sons and two daughters. Roger was 54 years old at the time of his death. Stephen was then 29 years old and his brother Graham was 33 years old.

Roger had very little relevant involvement with organisations during the period considered by the DHR (01/01/08 to 19/05/15). He had physical health problems, with diabetes being a chronic condition.

Stephen had more involvement with organisations during the relevant period, but not to the extent that would be considered exceptional by any of the agencies that took part in this DHR. A consistent theme was that Stephen reported suffering from depression arising from conflict within his family, although for the majority of the relevant period he was living elsewhere.

Graham had very little recorded involvement with organisations, none of which was relevant to the DHR.

There were four incidents in the relevant period that involved conflict between Roger and Stephen and which fitted the definition of domestic abuse that was current at the time. The first of these was in 2008 and was not recorded as domestic abuse by Kent Police, although they dealt with the incident it arose from. The other three incidents, which happened in subsequent years, were correctly recorded as domestic abuse. There was also an incident of domestic abuse in 2008, when Stephen alleged that he had been assaulted by his brother. This was dealt with, but not recorded as domestic abuse.

The only other time that an agency was aware of domestic abuse in the Hills family was when Stephen was undergoing a mental health assessment. He alleged that his father had abused him since he was a child, the last incident being when he was 24 years old. There are no further details about the nature of this abuse.

Stephen was involved in two incidents, less than three weeks apart, when he first threatened a neighbour and then when cut the arm of a man he was arguing with. On both occasions he used a knife. These incidents happened in mid-2013 and were while Stephen was living in his own flat some miles from the family home.

Stephen was then sentenced to a Community Order in 2013, following a conviction for criminal damage. He fully engaged and cooperated with the National Probation Service, who managed the Order. This was his only criminal conviction during the relevant period.

Stephen accessed mental health treatment through GPs, who prescribed him anti-depressants and on two occasions referred him to Kent and Medway NHS Social Care & Partnership Trust (KMPT), the providers of adult secondary mental health services in Kent. He was admitted as an inpatient by KMPT on two occasions, but following both the conclusion was that he did not have a mental health condition. It is clear from the records of all organisations that dealt with Stephen that his excessive drinking was a problem for him.

6. CONCLUSIONS

The Hills family, in particular Roger and Stephen, were known to organisations, but it is unlikely that they would have been viewed by any as a 'problem family' because the level and frequency of contact was not exceptional in the context of families that professional organisations deal with.

Graham had very few recorded contacts with organisations, none of which are relevant to this DHR. His only involvement with Kent Police was as a victim of crime when Stephen damaged his car.

Roger had no relevant contact with health organisations during the period covered by this DHR; the contact he had related to physical health conditions unconnected with domestic abuse.

On four occasions, Roger was involved in incidents with Stephen at the family home, each of which fitted the definition of domestic abuse that was in place at the time. On the first occasion, he alleged that Stephen had assaulted him. Kent Police did not record this incident as domestic abuse but correctly recorded the later three incidents as such. The Review Panel is satisfied that, had this incident happened today, Kent Police would have recorded it correctly because of the increased level of domestic abuse training that police officers now receive.

Stephen had more involvement with organisations, but not to an extent that would have been considered frequent in the context of families that organisations deal

with. In addition to the occasions referred to involving Roger, one additional incident involving Stephen fitted the definition of domestic abuse. This was when he alleged that his brother had assaulted him. Kent Police dealt with this in a pragmatic and proportionate way but did not record it as domestic abuse. The Review Panel is again satisfied that, had this happened more recently, Kent Police would have recorded it correctly.

With hindsight, the most significant incidents involving Stephen were when he threatened a neighbour with a knife and when he cut a man with a knife less than three weeks later. These incidents happened two years before he killed Roger and while he was living some miles away from the family home. If there was any concern that these incidents demonstrated a rapid escalation in violence by Stephen, or a propensity to use knives, this would have been allayed because he had no further contact with Kent Police involving violence for two years, until the day he killed Roger.

Stephen engaged fully with the National Probation Service (NPS). He attended all of his appointments and appeared to be interested and involved in the Reducing Reoffending Specified Activity Requirement sessions. Unlike almost all his involvements with Kent Police before he was sentenced, NPS staff never saw him drunk. Although he referred to family issues, he did not suggest that he had a violent relationship with his other family members. During the period that Stephen was subject to the Community Order managed by NPS, he did not have contact with Kent Police or health services.

On most of the occasions when Stephen visited his GP, he presented suffering from depression, although this was never formally diagnosed following mental health assessments carried out by KMPT staff.

As with physical health conditions, mental health problems, including depression, can range from minor through to life threatening. Most people suffering from depression access care and receive treatment through their GP. In most cases the GP will manage their condition and they will not receive treatment from secondary mental health providers.

Stephen was prescribed anti-depressants by GPs as the first step in managing his presentation. However, on two occasions he was immediately referred to KMPT, by different GPs. This suggests that the GP practice that Stephen was registered with had a clear understanding of the complementary nature of the relationship between primary and secondary mental health providers.

At his trial it was quoted that Stephen's IQ was 74, which is below average and indicative that a person is likely to suffer learning difficulties – a term that is commonly used and for which there are several definitions. Only a National Probation Service (NPS) professional used this term to describe Stephen's condition. This was based on a professional judgement, rather than a diagnosis or a knowledge of his low IQ.

Unlike mental health conditions, such as bi-polar disorder, psychosis or schizophrenia, 'learning difficulties' cannot be 'treated' with medication. Neither can a person with learning difficulties be 'cured'. What they are likely to require is additional support with day to day activities.

Professionals from agencies subject of this report (apart from NPS), who would be expected to provide additional support to service users with learning difficulties did not record identifying that Stephen might be such a person. It is not possible to judge whether this was because it was not evident, that they lacked the ability to identify it or because they lacked empathy. If learning difficulties are not identified, appropriate support is unlikely to be given.

The GPs who saw Stephen were aware of the tensions in his family because he told them. Depression caused by family tensions is a condition that GPs see on a frequent basis and, in most cases, it is not an indication that the patient will use violence. Stephen did not disclose anything to a GP that would have given rise to concern that he would become violent.

Stephen had contact with KMPT staff from the Community Mental Health Team, Crisis Resolution and Home Treatment Team, and Hospital A during the period covered by this Domestic Homicide Review. On two occasions, he was referred by his GP and on others he accessed KMPT services based in Hospital A, after initially attending his local A&E department.

Stephen had two periods as an inpatient at Hospital A and, on both occasions, the conclusion on his discharge was that he was not suffering from a mental health condition.

He disclosed three times that he had been a victim of violence at the hands of his father during his childhood. The first disclosure was to an Approved Mental Health Practitioner, when he said his father was a disciplinarian who had hit him as a child.

The second occasion was a year later (January 2010) when he told a trainee doctor at Hospital B A&E department of 'past childhood abuse' by his father. He said that the last incident had been in 2009. There was either a missed opportunity to

explore this further or a failure to record any further details that Stephen gave.

The third occasion was during a mental health assessment by a KMPT doctor and an Approved Mental Health Practitioner, just over a year after the second. There is no record that Stephen was asked more about this and this was again a missed opportunity to get a fuller background on which to base a judgement about what action was appropriate. There is no record that this allegation of childhood abuse was shared with any organisation, or that the possibility of doing so was discussed with Stephen.

In summary, in three separate contacts with health professionals in consecutive years, Stephen disclosed that his father had used violence against him when he was a child. The last occasion on which he made this allegation was four years before he killed his father. There was no record that this was ever explored further or that consideration was given to sharing the information with Kent Police.

The incidents of domestic abuse involving Roger and Stephen during the period covered by this DHR do not indicate a pattern of coercive control by either. There was no escalation in the severity of the incidents until the event that led to Roger's death. These incidents were an indication of a family that had tensions; they were not of a nature that should have caused professionals to conclude that either Roger or Stephen were vulnerable victims.

At his trial, part of Stephen's defence was that his father bullied him and he felt he was treated differently to Graham. What Stephen described in court showed coercive control and would have constituted domestic abuse of which he was the victim. However, no organisation was aware of the detail of what Stephen alleged had taken place, although there had been opportunities to explore this.

The Review Panel concludes that none of the professionals involved with Roger or Stephen could have reasonably foreseen the event that led to Roger's death.

7. RECOMMENDATION

The Review Panel makes the following recommendation from this DHR:

Recommendation	Organisation
Kent and Medway NHS and Social Care Partnership Trust must ensure that if patients disclose child abuse to professionals, the nature of this should be explored. Any further detail should be recorded and consideration given to sharing this information if serious criminal offences are disclosed because the patient may not have been the only victim.	KMPT

8. LESSONS LEARNED

Professionals must know what action to take when people disclose being victims of domestic and/or childhood abuse.

Stephen repeatedly referred to family tensions when speaking to health professionals, both at his GP surgery and when engaging with secondary mental health services. GPs in particular will hear many patients tell them that family issues are the cause of stress or depression. Such cases will not often result in death or serious injury and it is unrealistic to suggest that GPs should treat each case as if it is likely to.

However, when people disclose to professionals who have a responsibility for safeguarding, that they are or have been victims of violence at home, there is a greater onus to consider what action is appropriate. It takes considerable courage to disclose being a victim of violence in a family setting and it should be recognised as a cry for help in the most literal sense.

A professional to whom a person makes such a disclosure has a responsibility to obtain as much detail as the person is willing to give. This is essential in order to decide how the person can best be supported and how the disclosures they have made are best managed.

Organisations that employ staff who have responsibility for reporting safeguarding concerns must ensure that those staff have a clear understanding for how reports or referrals should be made following disclosure by a service user.

Continually raising staff awareness of the signs of domestic abuse and other safeguarding issues is important in learning this lesson. In Kent, members of the Kent and Medway Safeguarding Adults Board (KMSAB), which includes all the organisations in this review with the exception of Circle Housing Russet, are required to report on levels of training in relation to safeguarding, domestic abuse and the Prevent Strategy. Performance is monitored using a dashboard maintained by a committee that reports to the Board.

During the summer of 2016, Kent Police, as part of the Kent and Medway Domestic Abuse Strategy Group, will be repeating their 'You're Not Alone' campaign, first run in 2014. This aims to signpost victims of domestic abuse to the resources available in Kent and Medway to support them but it is also relevant to staff from agencies that deal with potential victims of domestic abuse.

The importance of accurately recording contact with service users, and the rationale for decisions.

The primary reason why accurate recording is important is that the record forms the history of a person's involvement with a professional service. It is possible that future engagement with that service will be made by a different professional. If they have frequent engagement, it may be with a number of professionals within that organisation.

Accurate record keeping allows those future engagements to be conducted with the fullest possible knowledge of the person's history. While it may take longer to make a full record of a contact, in the long run it will save time and allow subsequent engagements to be based on previous professional input.

While the benefit to service users is the main outcome achieved by accurate recording, there is also a benefit to professionals, particularly in recording the rationale for decisions.

Any subsequent investigation, enquiry or inquest is likely to look closely at why decisions were made. If a decision was made years before, it is unlikely that the professional will remember the rationale if they did not make a contemporaneous record. In any event, in an adversarial scenario, reliance on memory may be the subject of a strong challenge. An accurate and concise record of the rationale for a decision, made contemporaneously, will better enable such a challenge to be met.