

# **Domestic Homicide Review**

**Connie  
2018**

## **Executive Summary**

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Commissioned by:  
Kent Community Safety Partnership  
Medway Community Safety Partnership  
Review Completed: 31st March 2020

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## EXECUTIVE SUMMARY

### 1. The Review Process

- 1.1 This summary outlines the process undertaken by the Multi-Agency Review Panel in reviewing the death of Connie Smith, who lived in Kent.
- 1.2 Connie was not the victim of a homicide (the killing of one person by another), but paragraph 18 of the Multi-Agency Statutory Guidelines for the Conduct of Domestic Homicide Reviews states:

*Where a victim took their own life (suicide) and the circumstances give rise to concern, for example that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable.*

- 1.3 In accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004, the Chair of the Kent Community Safety Partnership decided that this criterion for a Domestic Homicide Review had been met and that a Multi-Agency Review (MAR) would be conducted using the DHR methodology set out in the statutory guidance. The review began in November 2018.
- 1.4 To protect the identities of Connie and her family members, she is referred to in this MAR by a pseudonym. Connie was a white British woman, who was in her 30s at the time of her death in August 2018.
- 1.5 The DHR Core Panel met in November 2018 and agreed that the criteria for an MAR were met. The Chair of the Kent Community Safety Partnership then made the formal decision that an MAR would be conducted. Agencies that potentially had contact with Connie and/or Ryan prior to Connie's death were contacted and asked to confirm whether they had contact with them. Those agencies that confirmed contact with Connie were asked to secure their files.

### 2. Contributing Organisations

- 2.1 Each of the following organisations were subject of an IMR:
- Kent Police
  - Kent Police (including Area A Multi-Agency Risk Assessment Conference)
  - Kent, Surrey & Sussex Community Rehabilitation Company
  - Centra (Domestic Abuse Service)

- GP Practice A (Connie's GP) \*
- Kent and Medway NHS and Social Care Partnership Trust
- Kent Community Health NHS Foundation Trust
- Area A NHS Trust\*
- South East Coast Ambulance Service NHS Foundation Trust
- Kent County Council Adult Social Care and Health
- Kent County Council Integrated Children's Services

\* To protect the anonymity of Connie, her GP practice and the NHS Hospital Trust covering Area A are not named.

2.2 In addition to the IMRs, the Independent Chairman conducted an interview with a senior representative of Connie's local housing association, the housing provider of the house in which Connie lived. Following the interview, the Independent Chairman completed a report, which was considered by the MAR Panel.

2.3 Kent County Council Adult Social Care and Health submitted a report to the review. Its involvement was peripheral and is not subject of further consideration in this report.

### **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 Connie.

3.2 The members of the panel were:

<b>Name</b>	<b>Organisation</b>	<b>Job Title</b>
Claire Axon-Peters	Kent & Medway Clinical Commissioning Group	Designated Professional for Safeguarding Adults
Catherine Collins	Kent County Council Adult Social Care and Health	Adult Strategic Safeguarding Manager
Alison Deakin	Kent and Medway NHS and Social Care Partnership Trust	Head of Safeguarding
Yvette Hazelden	Look Ahead Care Support and Housing (Domestic Abuse Independent Advisor)	Community & Strategic Lead
Leigh Joyce	Centra	Locality Business Manager
Dawn Morris	KCC Integrated Children's Services	Quality Assurance Manager
Paul Pearce	Independent Chairman	Independent Chairman
Shafick Peerbux	KCC Community Safety	Head of Community Safety

<b>Name</b>	<b>Organisation</b>	<b>Job Title</b>
Ian Wadey	Kent Police	Detective Chief Inspector
Jessica Willans	Kent, Surrey and Sussex Community Rehabilitation Company	Excellence and Effectiveness Senior Manager

3.3 Panel members had not had any contact or involvement with Connie during or prior to the review period. The panel met on three occasions during the MAR.

#### **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**

5.1 These terms of reference were agreed by the Multi-Agency Panel following their meeting in December 2018.

##### **5.2 Background**

5.2.1 On 30<sup>th</sup> August 2018, South East Coast Ambulance Service were called to a house in Area A, Kent by Ryan Davis, who had found his partner, Connie Smith hanged in the bedroom of the home she shared with their 2-year-old child (child B). Connie Smith was 33 years old at the time of her death.

5.2.2 At the time of Connie's death, there was a Restraining Order preventing Ryan from contacting Connie or attending her home. Information suggests that he may have been staying at the house on a permanent basis since his release from prison in June 2018.

5.2.3 Whilst Connie was not the victim of a homicide (the killing of one person by another), but paragraph 18 of the Multi-Agency Statutory Guidelines for the

Conduct of Domestic Homicide Reviews states:

*Where a victim took their own life (suicide) and the circumstances give rise to concern, for example that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable.*

5.2.4 Consequently, 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 20 November 2018. It agreed that the criteria for a multi-agency review (MAR) had been met and this review will be conducted using the DHR methodology.

5.2.5 That agreement has been ratified by the Chair of the Kent Community Safety Partnership and the Home Office has been informed.

### **5.3 The Purpose of the MAR**

5.3.1 The purpose of the MAR is to:

- a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- b) identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
- d) prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
- e) contribute to a better understanding of the nature of domestic violence and abuse; and
- f) highlight good practice.

### **5.4 The Focus of the MAR**

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



Connie Smith.

- 5.4.2 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.
- 5.4.3 If domestic abuse was identified, this MAR 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. 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 consider 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.
- 5.4.4 The subject of this review will be the deceased, Connie Smith.

## **5.5 MAR Methodology**

- 5.5.1. The MAR will be based on information gathered from IMRs, chronologies and reports submitted by, and interviews with, agencies identified as having had contact with Connie and/or Ryan in circumstances relevant to domestic abuse, or to factors that could have contributed towards domestic abuse, e.g. alcohol or substance misuse. The MAR Panel will decide the most appropriate method for gathering information from each agency.
- 5.5.2. Independent Management Reports (IMRs) and chronologies must be submitted using the templates current at the time of completion. Reports will be submitted as free text documents. Interview will be conducted by the Independent Chairman.
- 5.5.3. IMRs and reports will be prepared by an appropriately skilled person who has not any direct involvement with Connie or Ryan, and who is not an immediate line manager of any staff whose actions are, or may be, subject to review within the IMR.
- 5.5.4. Each IMR will include a chronology 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.
- 5.5.5. Each agency required to complete an IMR must include all information held about Connie or Ryan from 1 January 2015 to 30 August 2018. If any information relating to Connie being a victim, or Ryan being a perpetrator, of

domestic abuse before 1 January 2014 comes to light, that should also be included in the IMR.

- 5.5.6. Information held by a statutory agency that has been required to complete an IMR, which is relevant to Connie's death, 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 Connie and/or Ryan. If the information is not relevant to the circumstances or nature of Connie's death, a brief précis of it will be sufficient (e.g. In 2015, X was cautioned for an offence of shoplifting).
- 5.5.7. 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.
- 5.5.8. 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 MAR 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 MAR Panel and a final, agreed version will be submitted to the Chair of Kent CSP.

## **5.6 Specific Issues to be Addressed**

- 5.6.1 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 Connie, knowledgeable about potential indicators of domestic violence and 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 Domestic Abuse, Stalking and Harassment (DASH) risk assessment and risk management for domestic violence and abuse victims or perpetrators and were those assessments correctly used in the case of Connie? Did the agency have policies and procedures in place for dealing with concerns about domestic violence and abuse? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a Multi-Agency Risk Assessment Conference (MARAC) or other multi-agency forums?

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- iii. Did the agency comply with domestic violence and abuse protocols agreed with other agencies, including any 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. When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?
- vii. Was anything known about the perpetrator? For example, were they being managed under a Multi-agency Public Protection Arrangement (MAPPA)? Were there any injunctions or protection orders that were, or previously had been, in place?
- viii. Had the victim disclosed to any practitioners or professionals and, if so, was the response appropriate?
- ix. Was this information recorded and shared, where appropriate?
- x. Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?
- xi. Were senior managers or other agencies and professionals involved at the appropriate points?
- xii. Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?
- xiii. Are there ways of working effectively that could be passed on to other organisations or individuals?

- xiv. Are there lessons to be learned from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?
- xv. Did any staff make use of available training?
- xvi. Did any restructuring during the period under review likely to have had an impact on the quality of the service delivered?
- xvii. How accessible were the services to the Connie?

## 6. Summary Chronology

- 6.1 Connie Smith was a white British woman who was in her 30s at the time of death. She had two children, the elder being in their early teens and living with their father. Her younger child, aged 2 years at the time of death, lived with her at her home in Town A, Kent.
- 6.2 Connie had a history of mental illness and had first drunk alcoholic drinks and taken controlled drugs in her teens. Despite this, she had many friends at school, and she went on to college where she was awarded a degree in art.
- 6.3 After her elder child was born when Connie was 20 years of age, she separated from their father. She moved in with another partner, but that relationship also ended. Connie began drinking and taking drugs and following Family Court proceedings her eldest child went to live with their father.
- 6.4 In August 2015, Connie began a relationship with Ryan Davis, who she had known previously. By November of that year, she was pregnant with Ryan's child: she gave birth to Child B in August 2016.
- 6.5 The first report of domestic abuse between Connie and Ryan was in November 2015 when both were arrested for assaulting each other. Neither wished to support prosecution and no further action was taken. The next occasion was in August 2016, shortly after Child B was born. On this and subsequent occasions she was clearly the victim and DASH risk assessments carried out with her were always graded High.
- 6.6 In November 2016, Ryan was given a suspended prison sentence and a three-year restraining order for assaulting Connie. Between then and her death he twice

served prison sentences, firstly for breaching his restraining order and then for sending malicious text messages to Connie.

- 6.7 On the evening of her death, Connie was at home with Child B. Ryan was also there, in contravention of his restraining order. Connie went upstairs and when Ryan heard strange noises he also went upstairs, where he found that she had hanged herself from a curtain rail. Despite the efforts of paramedics, Connie died.
- 6.8 Connie had maintained contact with Ryan through much of the period following the incidence of domestic abuse when he received the restraining order. As her mother explained to the Independent Chairman of the MAR, Connie was a vulnerable woman who wanted someone to love her. In addition, her eldest child had already been removed from her care and she feared the same would happen with Child B. Her vulnerability was exacerbated by a cancer diagnosis in late 2017, which required her to have a major operation. As a result, she was unable to have further children.

## 7. Conclusions

- 7.1 Connie was a victim of domestic abuse who, in the last year of her life was suffering from mental health problems and cancer. Her eldest child had already been removed from her care and she was bringing up a young child, and was probably fearful the same would happen with Child B. Any one of these factors would have been stressful; together they made her extremely vulnerable. She needed not only safeguarding, but care. Reviews of this type tend to focus on safeguarding, but the value of inter-agency working is broader because it should also identify vulnerabilities that can be addressed by caring in addition to safeguarding. This is highlighted in cases such as Connie's, where death does not result from homicide but from a person becoming overwhelmed by the pressures on them.
- 7.2 Connie's mother was supportive of her, including providing an alternative place for her to live for a time. Although there are numerous examples of organisations providing a good service to Connie, there seems to have been a lack of appreciation of all the factors that contributed to her vulnerability. Each organisation understood the issue requiring its service, but there is no evidence that the immense weight of the problems she faced was appreciated.
- 7.3 Connie's engagement with organisations was not consistent. At times she would engage for months before stopping. During the last months of her life, organisations found it difficult to contact her. Although some organisations made considerable efforts to contact her and maintain engagement, there is little evidence that the possible reasons for her decision to disengage were explored. For example, there is no record that consideration was given to this

being due to her cancer becoming her overriding concern, or her fear that Child B would be removed from her care. The latter must have been a real worry for her because this had happened with her elder child. In addition, the operation she had to treat her cancer meant she could not have given birth again.

- 7.4 Most importantly, given that Connie was a high-risk domestic abuse victim, her reduced engagement could have been because she was subject to increasing coercive control. She began her relationship with Ryan after separating from her previous partner; the first known incidence of violence in the relationship with Ryan was in November 2015, about the time she became pregnant with Child B. There were no further reports of domestic abuse until two weeks after Child B's birth when Ryan subjected her to a violent assault. She reported this, but she did not always want to pursue police action against him.
- 7.5 Professionals trying to engage with Connie in the last few months of her life knew she was a high-risk domestic abuse victim; in the case of Centra, that was why they were attempting to contact her. A reluctance by her to engage with organisations should have first raised concerns that she was subject to coercive control. This concern should apply in all cases involving domestic abuse victims who decline to engage, and when it becomes harder to contact a victim, particularly if this has not previously been difficult.
- 7.6 Kent Police pursued prosecutions against Ryan when Connie was not supportive of this action. This was positive and resulted in him receiving prison sentences. Examples of failures to understand that Connie might be behaving in a way that was not wise due to coercive control, led Connie's local housing association to withdraw from a managed move process and Centra to close her case.
- 7.7 Connie's eldest child had been removed from her care and placed to live with their father; this caused her understandable distress. There is no evidence that the fear of this happening with Child B was considered as a possible reason why she sometimes seemed reluctant to engage with organisations.
- 7.8 Recommendations have been made in Section 11 when issues relating to individual organisations have been identified, and which could be addressed to improve the safeguarding and support given to domestic abuse victims in future. The wider issue is the need to consider a victim's whole life circumstances when considering their vulnerability and the support they need.

## **8. Lessons Identified**

### **8.1 Professionals dealing with victims of domestic abuse must look at issues through the eyes of the victim.**

8.1.1 This is necessary to ensure that responses are appropriate to individuals and not simply the result of adherence to policy. It may be frustrating for professionals when domestic abuse victims keep in contact with perpetrators. Connie's mother highlighted how vulnerable Connie was and how she wanted to be loved.

8.1.2 Information sharing and seeking are important to gaining a clear understanding of the issues the victim is experiencing and possible motives for decisions they take that may not seem to be in their best interests, at least from a professional's point of view. A number of factors can influence the decisions such as maintaining a relationship with an abusive partner or declining offers of support. Moving away from a one size fits all approach to an evidence-based approach for developing a needs-led set of interventions may allow offers of support that are better tailored and therefore accepted.

### **8.2 If a domestic abuse victim becomes more difficult to engage, professionals must consider whether this might be because she or he is subject to coercive control.**

8.2.1 People are entitled to decline to engage or stop engaging with organisations; they do not have to justify their reasons for doing so.

8.2.2 Some organisations have policies for managing people who decline to engage or stop engaging. Others may consider withdrawing their efforts to engage on a case-by-case basis. In either case, the organisation needs to be able to demonstrate a consistent approach. In the case of people who are identified as victims of domestic abuse, the approach must not be mechanistic; it should consider why the person is not engaging.

8.2.3 When considering withdrawing service from a person who is a domestic abuse victim, a primary consideration must be that if she or he does not or will no longer engage, this may be due to them being subject to coercive control. Disengaging may make the person more vulnerable to harm. Every effort should be made to establish their current circumstances from other organisations who are dealing with the person before deciding to withdraw the service.

### **8.3 The vulnerability of a domestic abuse victim to coercive control may be**

**increased by other factors in their life and professionals must take all the issues known about the person into account when making decisions about safeguarding and supporting victims.**

8.3.1 As is clear from Connie’s case, other life factors such as mental and physical health, and child residency, are likely to increase a victim’s vulnerability and may influence their assessment of risk.

8.3.2 Professionals cannot prevent a domestic abuse victim with mental capacity from making decisions that they may not agree with, but they should consider all life factors when deciding how best to provide safeguarding and support.

## 9. Recommendations

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

	<b>Recommendation</b>	<b>Organisation</b>
1.	Kent Police must have process in place to ensure that intelligence received (from any source) about domestic abuse, particularly if it refers to a high-risk victim, is evaluated and disseminated expeditiously to the relevant department to ensure it is acted upon appropriately.	Kent Police
2.	Kent County Council must, as part of the performance monitoring of its contract with Centra, consider how the concerns identified in this report are being addressed by Centra to ensure that the service provided to high-risk victims of domestic abuse is improved.	Kent County Council
3.	Clinical Commissioning Groups should ensure that when it is known to a GP practice that a patient is a victim of domestic abuse, this is clearly highlighted in their notes if they transfer to another practice.	CCGs in Kent and Medway
4.	Kent and Medway CCGs should encourage GP practices that have electronic recording systems for patients’ notes with a flagging facility, to use this to flag patients (and where relevant, children and other family members) who are victims of domestic abuse.	CCGs in Kent and Medway



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	<b>Recommendation</b>	<b>Organisation</b>
5.	Kent and Medway Domestic Abuse and Sexual Violence Group should consider how best to ensure that a high-risk domestic abuse victim's GP is invited to attend or contribute to a MARAC meeting at which one their patients will be discussed.	Kent and Medway DASVG
6.	KMPT must ensure its doctors understand the need to inform its Safeguarding Lead about patients who are at risk of domestic abuse.	KMPT
7.	Area A NHS Trust should ensure that initial and refresher training for staff includes emphasis on asking patients about domestic abuse, including coercive control, when completing the Concern and Vulnerability Form.	Area A NHS Trust
8.	KCC Integrated Children's Services should consider inviting housing providers to Initial Child Protection Conferences.	KCC Integrated Children's Services
9.	KCC ICS must ensure that safeguarding training for its staff includes the safeguarding responsibilities of the service beyond its primary role of child protection, including the need to share safeguarding concerns with other relevant organisations	KCC Integrated Children's Services
10.	Kent and Medway Domestic Abuse and Sexual Violence Group should: ask the housing association to report on the additional training provided to its staff; and consider circulating details to other housing associations in Kent and Medway.	Kent and Medway DASVG