Domestic Homicide Review

Paul/2012

Executive Summary

Author: Helen Carter

Commissioned by:
Kent Community Safety Partnership
Medway Community Safety Partnership

Note:

The report has been anonymised and all the personal names contained within it, with the exception of references to members of the review panel, are pseudonyms.

1. Introduction

The law says that when someone dies as the result of domestic abuse there must be a multi-agency review, a Domestic Homicide Review (DHR), to review what happened so that lessons can be learned, changes made and future risks reduced.

This summary outlines the background to and findings of the review into the death of Paul who died following a stab wound in September 2012. Paul's partner, Katie, was charged with his murder. It was in this context that the Kent and Medway Community Safety Partnership commissioned a statutory DHR.

Katie was tried for murder at the Crown Court and found not guilty of either murder or the lesser charge of manslaughter.

The agencies involved with both Paul and Katie had, by the time of the acquittal, substantially completed their analysis of their involvement with the couple, whether individually or together. They agreed that even though the circumstances of Paul's death no longer fell within the definition of a domestic homicide there were useful lessons that could be learned that might help reduce the risk of domestic abuse in the future and that the review should therefore be completed.

2. The purpose of the review

The key purpose for undertaking a DHR is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence. In particular, they focus on establishing

- what lessons are to be learned regarding the way in which local professionals and organisations work individually and together to safeguard victims of domestic abuse
- how and when these lessons will be acted upon

with the aim of preventing domestic abuse homicide and improving services for all domestic abuse victims and their children through improved intra and inter-agency working.

The Home office sets out a number of standard elements to be included as part of the terms of reference for all DHRs. These were incorporated into the agreed terms of reference for this review which also considered a number of specific issues relevant to the circumstance of the case, including whether both Katie's and Paul's mental health and alcohol/substance abuse status had been accurately assessed and dealt with appropriately.

Both Paul and Katie had children from previous relationships and Katie was pregnant at the time of Paul's death. While it was not the purpose of this review to consider the handling of any child protection concerns which may be related to the case, it was recognised that there may be issues that arise that relate to the safeguarding of children who may be affected by domestic abuse. It was agreed that if this proved to be the case, the issues would be raised, by the relevant agency, with the relevant Safeguarding Children Board.

3. The Review Process

The review was conducted as set out in the relevant Home Office guidance. An independent chair was appointed to oversee the process with the assistance of a DHR Panel made up of senior representatives from:

- KCA (Substance Misuse Service)
- Kent and Medway NHS and Social Care Partnership Trust (KMPT)
- Kent & Medway Clinical Commissioning Group (CCG)
- Kent & Medway Domestic Violence Co-ordinator
- Kent County Council (KCC) (Community Safety)
- Kent County Council (KCC) (Families and Social Care, Adult Services)
- Kent County Council Commissioned Services (Kent Drug and Alcohol Action Team – (KDAAT))
- Kent Police
- Kent Probation
- Medway Council
- Thanet Council

Agencies were asked to give chronological accounts of their contact with the Paul and/or Katie prior to Paul's death. These individual management reviews (IMRs) were intended to cover the following:

- A detailed chronology of their interaction with Paul and/or Katie.
- Whether internal procedures were followed and the impact of this.
- Analysis, lessons learned, conclusions and recommendations for an agency action plan.

Where there was no involvement or insignificant involvement, agencies advised accordingly.

The time period to be covered by the IMRs was set as being from January 2012, when Paul and Katie are first thought to have associated with each other until Paul's death in September that year. Report authors were asked to exercise their professional judgement and include detail which fell outside of this period if it was particularly relevant to the review's terms of reference.

Some of the accounts have more significance than others. Training for review authors was offered and a standard template provided for their use. Nevertheless, there was considerable variation in both the quality and the presentation of the individual reviews. Where appropriate, further information and clarification was sought.

The following agencies submitted IMRs:

- Bart's Health
- East Kent Hospitals University Foundation NHS Trust
- KCA (Substance Misuse Service)

- Kent & Medway NHS & Social Care Partnership Trust
- Katie's GP Surgery
- Kent Community Healthcare Trust
- Kent Probation
- Paul's GP Surgery
- Oxleas NHS Trust
- Thanet Housing

It was agreed that, given the nature and extent of their contact with either Paul or Katie, it would be sufficient for Kent County Council Specialist Children's Services to submit a chronology.

Kent County Council Adult Social Services could find no record of contact with either Paul or Katie during the relevant period and did not, therefore, submit either a chronology or an IMR.

These reviews, and responses to subsequent enquiries, form the basis of the overview report.

In accordance with Home Office guidance, both Paul's family and Katie were notified of the review and its purpose and asked if they wished to see/comment on the draft report. A number of ways in which they might make their views known were suggested, neither chose to respond.

The Panel had regard to the statutory guidance on the involvement with friends, family members and other support networks. In Paul's case, there was no information to suggest friends or other identifiable networks of whom it would be helpful to approach. The views of some of Katie's friends were reflected in the material available to the panel.

4. Background

The review focuses on Paul and Katie. At the time of Paul's death in September 2012, they had been in an intimate relationship for approximately 6-9 months and Katie was pregnant by Paul. Both had children from previous relationships, though neither had custody of their children. Paul had little, if any contact with his children. Katie's contact with her son appears to have increased during the period covered by the review and it is evident that Paul also had contact with him and was increasingly involved in his care.

Paul and Katie both had an extensive history of crime, alcohol and drug abuse. Paul had been arrested several times for assault. He also had a history of domestic abuse/violence; 9 incidents are recorded against him since April 2003. Katie also had a criminal record for crimes involving violence, including 7 offences against the person (2006- 2009).

The only recorded incidence of potential domestic abuse between Katie and Paul occurred on 30th April 2012. They had a heated argument outside their local Police Station.

Whilst this was the only reported incident, it is evident from the detail of the chronology contained in the full report that Paul and Katie had a turbulent and apparently deteriorating relationship. Although Katie had previous convictions for assault and had assaulted a previous partner, the only recorded or suspected incidents of domestic abuse during her relationship with Paul show her as the victim, not the perpetrator.

Prior to Paul's death, this relationship appears to have been 'on/off' for some of the time. At the very least, this is how it was presented to various agencies. The apparently 'on/off' nature of their relationship potentially made it difficult for agencies to make a realistic assessment of risk of the likelihood of domestic abuse. It is also potentially a 'red flag' that should have alerted them to the potential of an increased level of risk.

In September 2012 Katie telephoned South East Coast Ambulance Service to report that her partner, Paul, had been stabbed. Paramedics and police attended the address where Katie lived with Paul. Paul was taken to hospital and subsequently died of his injury.

The Police found knives, blood on the wall and furniture and signs of a disturbance in the flat that Paul shared with Katie. Katie stood trial for Paul's murder in April 2013. She pleaded 'not guilty' and was acquitted. At her trial, she reported that she had been a victim of domestic abuse at Paul's hands.

5. Issues arising from the review

Like many victims of domestic abuse, Katie was reluctant to report it and unwilling to engage with support services. There may be a number of factors, including the complex nature of relationships in which domestic abuse is a feature which underpin a victim's apparent reluctance to seek help or to accept it when offered. The Review Panel also thinks it likely that anyone who engages in frequent criminal activity and who is arrested and held in custody by Police may be reluctant to engage with or trust them on other matters. This raises potential policy issues for how such services are organised and delivered. It also underlines the importance of all relevant agencies and service providers being aware of the signs/symptoms of domestic abuse and how they should be dealt with.

The review identified significant gaps, particularly within health providers, in some organisations' awareness and understanding of domestic abuse and their roles and responsibilities in identifying and helping people at risk. Of particular concern is the fact that, within health, there was no evidence of current risk assessment tools being used by any provider when disclosures of previous domestic violence were made. This is symptomatic of one of the underlying themes identified by this review of a tendency, observed across a number of agencies, to take things at face value and treat the symptoms rather than the whole person.

Throughout the period covered by the review, Paul and Katie continued to use drugs and alcohol heavily. When asked about it by Health and Probation staff, they repeatedly understated their drug and alcohol consumption. Alcohol and drug misuse are both known to be factors which can be linked to increased risk of domestic abuse and of other criminal behaviour. Professionals need to recognise the warning signs and to be confident and skilled in challenging and interpreting self-reported consumption rates, yet Paul's and Katie's self-reports went largely unchallenged, even when their claims were not credible in the light of previously acknowledged levels of use.

Agencies and service providers faced a number of challenges when trying to contact/keep track of Paul or Katie. They had multiple aliases and addresses. The address chronology suggests that they sometimes moved back and forth between addresses rather than moving from one to the next in a linear fashion. Katie had poor literacy levels. All these factors increased the challenge to professionals in communicating with them and in identifying and assessing risk. As such, they underscore both the importance of robust and well understood communication policies and information sharing protocols.

During the period of the review there were several instances, across several agencies, where Paul - known by some to have perpetrated violence against Katie and by others to have the potential to do so – was asked to pass a message onto her or was present during a meeting about a matter which he might not wish to be pursued with her. In these circumstances it is possible that, at best, the message might not get passed on and that, at worst, it might be a catalyst for further abuse. It is of concern that this risk was not identified at the time.

Whilst there were some instances of good practice, a number of agencies appeared to work more or less in isolation, such that they routinely missed opportunities to alert other agencies to safeguarding concerns or failed to share information and risk assessments in a timely way.

In particular, there were a number of apparent failures to identify potential risk to Katie's son and/or her unborn children and/or to notify the relevant agencies. These risks were, in the main, associated with Katie's own behaviour including her drug and alcohol use, mental health, her own offending behaviour and that of the people she was known to be associated with. Again, this is symptomatic of a tendency to see things in isolation rather than to consider and work with the person within their familial and social context.

6. Overall conclusions

One of the key questions a DHR has to consider is whether the homicide could have been predicted and prevented. In this case, Katie was acquitted of both murder and manslaughter and the question is therefore redundant.

There was no evidence that Katie had ever initiated violence against Paul and, to that extent, had the jury found her guilty of his murder or of manslaughter it seems unlikely that the review would have concluded that this could have been predicted or prevented.

It is clear that Paul and Katie had a turbulent and apparently deteriorating relationship. This was exacerbated by their use of alcohol and illicit drugs. Although both had been referred for treatment there is little, if any, evidence to suggest that either were sufficiently motivated to address their substance abuse/engage fully in the process.

Equally it is clear that at least five children would potentially be impacted by any change in Paul or Katie's exposure to risk of violence or domestic abuse. There is mixed evidence about the extent to which service providers considered these wider safeguarding issues and/or the potential for either Paul or Katie to be the victim, rather than the perpetrator, of domestic abuse.

Given the volatility of Paul and Katie's relationship, their history of abusive relationships, chaotic lifestyles, mistrust of authorities and continuing failure to engage, it seems likely that the violence between them would have continued to escalate.

There were a number of factors to suggest that Katie, rather than Paul, was more likely to be at risk of domestic abuse within their relationship and that that risk was increasing. There were differing levels of knowledge across agencies about potential indicators of domestic abuse and awareness of the actions to be taken if there were concerns. In some cases the signs were not spotted. Where they were spotted, this tended to be in isolation: no one saw them together as a whole.

Some steps have already been taken to address this. More work remains to be done however, and the recommendations and the resulting action plan are designed to address the gaps that remain.

It was also evident that there was variable knowledge across agencies about the domestic homicide review process and its statutory nature. The willingness and capacity to engage also varied between agencies. These factors are also addressed in the recommendations.

7. Recommendations

A number of organisations have already taken actions which go some way to addressing the failings and lost opportunities identified by this review. Some are also continuing to progress the action plans agreed as part of their own IMR. The recommendations that are summarised below[1] are additional steps the panel consider necessary. They are reflected in a detailed action plan which will be monitored by the Kent & Medway Community Safety Partnerships.

Recommendation 1

All agencies should review their domestic abuse policies, procedures, risk assessment tools and training with a particular emphasis on:

[1] For the full wording of the recommendations, please see the main report.

- Ensuring, as far as possible and appropriate, a common approach and language is used.
- Ensuring that apparently isolated or infrequent incidents are viewed in their wider context.
- Building front line staff skills and confidence.

Recommendation 2

This recommendation, whilst similar, to recommendation 1, focuses on various health providers and recommends that:

- The adequacy and efficacy of the Kent surgery's domestic abuse policy and training should be independently assessed and, if appropriate, remedial action taken.

- The adequacy and efficacy of the EKHUFT's domestic abuse policy and training of A&E staff should be independently assessed and, if appropriate, remedial action taken.

- CCGs should encourage GP surgeries to review their domestic abuse policies and training and, where necessary, to take positive action to improve their understanding and practice. In this context, the learning from this review suggests that it will be particularly important to ensure that staff, whether clinicians or not,
    - are aware of their role/responsibilities with regard to identifying domestic abuse
    - are aware of the key signs to be aware of with regard to domestic abuse
    - and that clinicians feel able to initiate conversations and routinely enquire about potential abuse.

It was further recommended that a rolling audit programme of domestic abuse policies, practice and training across GP surgeries in Kent and Medway be undertaken. The aim will be to work with them to improve their understanding and practice. It appears that there is no body that is statutorily responsible for this and, consequently, no funding is available. This is a serious omission and will be drawn to the attention of the Home Office.

Recommendation 3

Agencies and service providers should routinely ask services users, at every visit, for information about how best to contact them. For service users known to be at particular risk of failing to attend, more than one means of communication should usually be used.

Recommendation 4

The delivery of Alcohol Identification and Brief Advice Training should be expanded to Health and Social Care providers.

Recommendation 5

A comprehensive risk assessment should be made available by Probation staff to substance misuse providers as soon as the initial referral is made.

Recommendation 6

The membership and processes of the Central Referral Unit (CRU) should be reviewed to ensure that mental health and substance misuse issues are properly managed and providers consulted appropriately.

Recommendation 7

Referral pathways between Court Diversion/Custody Liaison Service and DIP (Drug Interventions Programme) should be formalised and agreed to support the correct diagnosis and treatment of individual service users.

Recommendation 8

With the patient's consent, health professionals should, wherever possible, directly refer to drug and alcohol services in preference to or alongside asking the patient to self-refer, and follow up these referrals to monitor patient compliance.

Recommendation 9

Revised DHR and IMR training and standard letters/support materials (in development) should be implemented.

Recommendation 10

The Children's Safeguarding Board should formally review the various children's safeguarding concerns raised in this report and agree an appropriate action plan.

Recommendation 11

Kent Children's Specialist Services should review the timing of and the quality of information used to make the decision to close the cases referred to them by probation in respect of Katie's son and unborn twins.