

Executive Summary

FL /2011

Domestic Homicide Review

1 INTRODUCTION

1.1 Background to the Review

1.1.1 This summary outlines the process undertaken by Kent domestic homicide review panel in reviewing the death of FL in the context of domestic abuse.

1.1.2 Criminal proceedings have been completed and KT, FL's partner, was found not guilty of his manslaughter.

1.1.3 The purpose of the review was to:

- establish what lessons are to be learned from FL's death regarding the way in which local professionals and organisations work individually and together to safeguard victims of domestic abuse;
- 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;
- apply these lessons to service responses including changes to policies and procedures as appropriate; and
- prevent domestic abuse homicide and improve service responses for all domestic abuse victims and their children through improved intra- and inter-agency working

1.2 Review Process

1.2.1 The process began with an initial meeting on 3 February 2012 of all agencies that potentially had contact with FL and KT prior to FL's death.

1.2.2 Agencies participating in this case review are:

- Kent County Council
- Kent Police
- NHS Kent and Medway
- Kent and Medway NHS and Social Care Partnership Trust
- East Kent Hospitals University Foundation NHS Trust
- KCA
- CRI
- Kent Probation

- London Probation Trust
 - South East Coast Ambulance Service
 - Alcohol Rehabilitation Unit
- 1.2.3 Agencies were asked to give chronological accounts of their contact with both FL and KT from the date when they met in January 2010 until FL's death and to include any relevant information prior to January 2010. Where there was no involvement or insignificant involvement, agencies advised accordingly. Each agency's report covers the following:
- a chronology of interaction with FL and KT;
 - what was done or agreed;
 - whether internal procedures were followed; and
 - conclusions and recommendations from the agency's point of view.
- 1.2.4 The accounts of involvement with FL and KT cover different periods prior to FL's death. Some of the accounts have more significance than others. The extent to which the key areas have been covered and the format in which they have been presented varies between agencies.
- 1.2.5 All thirteen agencies contacted responded that they had some level of involvement with FL and/or KT. Medway Council's involvement with KT and her children ended in 2006 so they were not requested to submit a report to the review. Likewise, Kent County Council's Children's Social Services had no dealings with the couple during 2010/11, as KT's children had moved to live with their father before she met FL. Therefore, they were not requested to complete a report for the review.
- 1.2.6 Kent police included the historical involvement of Essex police and the Metropolitan police with FL in their chronology and also addressed the involvement of Devon and Cornwall police with the couple during the period covered by the review.
- 1.2.7 The police report shows that on fourteen occasions between May 2010 and May 2011 the police had contact with the couple; there were six incidents of domestic abuse in Kent, two in another police area, one incident of FL allegedly harassing KT's ex husband, two incidents of harassment of KT's sister, one incident of criminal damage by KT, one incident of self harm by FL, and one incident of both being drunk in the street.
- 1.2.8 The incidents of domestic abuse entailed violence between the couple; neither wished to pursue charges against the other, and KT denied for the most part that she was afraid of FL. FL received a fixed penalty notice for possession of an offensive weapon in June 2010, he received a conditional discharge for criminal damage to their home in September 2010, he was convicted in January 2011 of causing intentional harassment and alarm against KT between 1

December 2010 and 1 January 2011, and was made subject of a two year community order. He was fined for causing criminal damage to their home in February 2011. In May 2011 KT was cautioned for an assault on FL.

1.2.9 Several other agencies (including specialist domestic abuse agencies) responded as having no trace of FL and KT on their records.

1.2.10 The following agencies submitted individual management reports of their involvement with FL and KT:

- Kent police
- Kent Probation
- London Probation Trust
- Kent and Medway NHS and Social Care Partnership Trust
- East Kent Hospitals University Foundation NHS Trust
- KCA
- Sussex Partnership NHS Foundation Trust on behalf of CRI

1.2.11 Additionally briefing reports were received from four agencies that had limited contact with the couple during the relevant period and had information that would assist the review:

- Kent Families and Social Care (Adult Services)
- GP
- South East Coast Ambulance Service
- alcohol rehabilitation unit

1.2.12 Family input to the Review

Relatives of both FL and KT were notified of the review by their family liaison officer. It was agreed that KT's sister and ex husband and FL's nephew should be given the opportunity to meet with the overview report author. They were all sent letters via their family liaison officer and invited to meet her. None of them took up this option. Following her acquittal, attempts were made to contact KT to invite her to meet the author. These were unsuccessful.

1.3 The Review Panel

1.3.1 The review panel membership was as follows:

- Helen Davies, independent chair and overview report writer (an independent consultant)
- Tina Draper, NHS Kent and Medway
- Tim England, Medway Community Safety
- Alison Gilmour, Kent and Medway Domestic Violence Coordinator
- Carol McKeough, Kent Families and Social Care
- Maurice O'Reilly, Kent Probation
- Shafick Peerbux, Kent Community Safety
- Tim Smith, Kent Police
- Tracey Tipping, KCA

2 KEY ISSUES ARISING FROM THE REVIEW

- 2.1 FL and KT were in a dysfunctional relationship in which both were known to be violent. They both had long histories of dependency on alcohol, and their excessive alcohol consumption contributed to the verbal and physical abuse. FL was known to have paranoid feelings and hear voices, and KT had a history of depression. Both had suffered abuse in their childhoods. FL had a history of violence including domestic abuse, while KT's violence appears to have been limited to this relationship. They had additional stress factors of social isolation and leading a transient lifestyle in a motor home. In the light of all these factors, escalating violence could have been predicted, with either party being a victim.
- 2.2 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. There was limited consultation by NHS staff with safeguarding/domestic abuse leads in the NHS Trusts or with the police public protection unit.
- 2.3 There was a lack of consistency in the use of Domestic Abuse Stalking and Harassment (DASH) risk assessment with this couple. NHS staff did not use it all; the police used it appropriately but did not always consider historical information and its cumulative impact. Probation staff used a different offender centred risk assessment tool for cases of domestic abuse, but did not complete it fully or update as circumstances changed.
- 2.4 There was a lack of clarity in most agencies about the referral process for a Multi-Agency Risk Assessment Conference (MARAC). The threshold for MARAC was also an issue. Only cases assessed as high risk in the DASH model are referred to MARAC (and in this case the DASH assessments were all 'medium' or 'standard'). However, cases such as this, when several DASH assessments have been completed in a short period, may warrant referral to

- MARAC even when individual assessments have been graded as standard or medium risk.
- 2.5 Probation practice lacked rigour in use of the Spousal Assault Risk Assessment tool (SARA), in updating risk assessments as new information came to light, and in enforcing orders when there was lack of compliance.
 - 2.6 A coordinated approach across the three agencies most closely involved with the couple (police, probation and community addiction service) would have improved information sharing and possibly improved intervention with the couple. Such an approach is particularly indicated when alcohol or drug misuse is a feature of domestic abuse.
 - 2.7 It is difficult to intervene effectively with a couple engaged in an abusive relationship whose lifestyle is transient. There were inevitably gaps in information sharing between agencies.
 - 2.8 When both partners in an abusive relationship are misusing alcohol and minimise the severity of the abuse because they wish to remain together, an approach that includes home visits and engagement of both partners together could improve the quality of assessment and intervention. Accredited toolkits (eg by the STELLA project) for working with cases which feature both domestic abuse and alcohol misuse were not used in this case.

3 CONCLUSIONS

- 3.1 FL and KT were in a co-dependent relationship and denied, for the most part, the level of abuse in their relationship and were determined to remain together. Therefore, prevention of escalating violence was very difficult. While a more coordinated inter-agency approach would have been desirable, it is unlikely to have prevented escalating violence unless the couple were ready to address their alcohol dependency or unless they were forcibly separated from each other. Probation had grounds to breach FL for not complying with his order, but had they done so, it is unlikely that he would have received a custodial sentence.
- 3.2 This review has identified a number of ways in which practice within and between agencies could be improved. In particular, it has highlighted the need for better information sharing and more integrated working between agencies involved with a couple whose relationship is abusive and violent.
- 3.3 It has also identified the need for awareness raising and training of front line staff in indicators of domestic abuse, DASH assessment skills, and the MARAC process.
- 3.4 A number of services were available to assist the couple to address their abusive relationship and their alcohol dependency. However, neither party was motivated to access these services or engage with them in a meaningful way. Given these circumstances, it is difficult to conclude that escalating domestic abuse and FL's death could have been prevented. It is clear, however, that there are ways in which services to couples similar to FL and KT can be improved, and the overview recommendations are designed to ensure this happens.

- 3.5 The recommendations arising from this review have been collated into an action plan agreed by senior managers of the relevant agencies.

4 RECOMMENDATIONS

- 4.1 NHS Kent and Medway/Clinical Commissioning Groups to ensure that all health providers and GPs understand and respond to statutory guidelines, best practice, and local policy and procedures for domestic abuse.
- 4.2 NHS Kent and Medway/ Clinical Commissioning Groups, to ensure that all health organisations, including providers and GPs, understand and meet their statutory responsibilities towards domestic homicide reviews.
- 4.3 NHS Kent and Medway/Clinical Commissioning Groups to request NHS providers to identify leads in domestic abuse within each organisation and develop a domestic abuse strategy to include responsibilities from Board level to individual staff.
- 4.4 NHS Kent and Medway/Clinical Commissioning Groups to request NHS providers to develop and initiate a domestic abuse training strategy, and to request GP practices to undertake basic awareness training.
- 4.5 Kent and Medway Community Safety Partnership to ask all member agencies to ensure that their frontline staff understand the MARAC referral process, including issues of consent.
- 4.6 When six DASH assessments have been graded as 'medium' or 'standard' in a rolling 12 months period, Kent police should review the case and consider referral to the Public Protection Unit as a High Risk case.
- 4.7 When conducting risk assessments, in addition to the DASH process, Kent police should take into account past information and intelligence data.
- 4.8 Kent and London Probation to ensure that, in cases of domestic abuse, Spousal Assault Risk Assessments (SARAs) are completed to a consistently high standard, that risk assessments are kept under review, and orders are enforced rigorously.
- 4.9 Kent Probation to ensure that other relevant agencies are fully involved in risk assessment and risk management of domestic abuse cases.
- 4.10 Kent Probation and substance misuse services to ensure that there is closer liaison and more rigorous application of compliance with alcohol treatment orders.
- 4.11 Kent and Medway DAATs to ensure that agencies that support and treat individuals with substance misuse issues are aware of domestic abuse toolkits (eg STELLA project toolkit), and use them appropriately.

Helen Davies

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