

Domestic Homicide Review

Cydney/2011

Executive Summary

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

Ref: Cydney / 2011

Executive Summary

1 The Review Process

- 1.1 This is the executive summary of a Domestic Homicide Review (DHR) commissioned by the Kent and Medway Community Safety Partnerships. On 10th September 2011 a woman, her baby and her father died in an arson attack on her parent's home in Medway. The woman's mother and brother were also injured. The main purpose of a DHR is to establish lessons to be learned by examining the way that individuals and organisations work to safeguard victims of domestic abuse.
- 1.2 The review was conducted in accordance with the Domestic Violence, Crime and Victims Act 2004. The Kent and Medway Domestic Homicide Review Core Panel met on 6th October 2011 and agreed that this homicide should be subject to a review and commenced the process.
- 1.3 The review was conducted by a multi-agency panel consisting of senior representatives of agencies from Kent and Medway who are involved in providing domestic abuse services. The review panel was independently chaired. The panel considered reports from the agencies involved with the family and a final report was written by the Independent Chair and approved by the panel that met on four occasions.
- 1.4 This review examined the services provided to the victim, the offender and their baby. The time period considered was 1st January 2007 until 11th September 2011.
- 1.5 Pseudonyms have been used to protect the identity of the family members.

2 Circumstances of the homicide

- 2.1 Cydney was 20 years old and her son Solomon was 15 months old when they were murdered. She had returned to live with her parents in Medway in April 2011, having separated from her husband Derek, after he had assaulted her whilst they were living in Coventry. They had known each other since she was 14 years old and were married in 2009. Derek was Asian of Middle Eastern background and had been granted indefinite leave to remain in the UK, having come to England as an asylum seeker in 2005. He became a UK citizen as a result of their marriage. Cydney was White British. In the early hours of 10th September 2011 Derek and a friend went to Cydney's parent's house and set light to petrol that they had

sprayed through the letter box. Cydney and Solomon's bodies were found after the fire was extinguished. Cydney's father died a few days later.

- 2.2 After an investigation Derek, his friend and Derek's girlfriend were arrested by Kent Police and were later charged with offences in connection with the murder. After a trial at the crown court all three of them were convicted of numerous offences and sentenced to imprisonment. Derek was convicted of murder and other offences and was sentenced to life imprisonment.

3 Agency involvement

- 3.1 The agencies involved in the review were:-

- GP in Coventry and Medway
- Coventry and Warwickshire NHS Partnership Trust
- Midwifery Services and Health Visiting Coventry
- Health Visiting Medway
- Coventry Children's Social Care
- West Midlands Police
- Medway Council Housing Service
- Medway Citizens Advice Bureau
- Kent Police
- Kent Fire and Rescue Service

- 3.2 The agencies provided chronological accounts of their contact with the offender, the victim and their baby prior to the homicide. These reports also contained an analysis of the service provided; this was achieved by comparing what happened and what was expected in accordance with existing policy and good practice within that agency and on a cross agency basis. Each agency also submitted recommendations for their own agency and where appropriate for multi-agency working based on the conclusions of their review.

- 3.3 There was only one allegation of domestic abuse by Cydney which occurred on 1st April 2011 in Coventry when Derek assaulted Cydney causing minor injuries. Derek was arrested and was cautioned for assault. As a consequence of this assault Cydney left Coventry with Solomon immediately and moved into live with her parents in their house in Medway.

- 3.4 The West Midlands Police responded positively to the allegation by the immediate arrest of Derek. A risk assessment of Cydney was not carried out which was contrary to the current policy, the officer who should have carried out the assessment misinterpreted the guidance. A multi-agency screening process for incidents of domestic abuse where children are

- resident also did not occur due to a back log of reports. The West Midlands Police did review the incident in August 2011 and decided to pass the details to the health visiting service in Coventry even though they were aware that Cydney intended to move to Medway. The health visiting service in Coventry then forwarded the report to the health visiting service in Medway but it did not arrive until after the homicide.
- 3.5 On the 4th April 2011 Cydney was seen by a Independent Domestic Violence Advisor (IDVA) employed by Medway Citizens Advice Bureau who are contracted to provide this service by Medway Council's Housing Department. During the interview Cydney disclosed details of a history of domestic abuse by Derek. A risk assessment was carried out and the outcome of the assessment was that Cydney did not meet the criteria for automatic referral to a Multi-Agency Risk Assessment Conference. However the IDVA did conclude that it was not safe for Cydney to remain living at her parent's house or within Medway, as it was probable that the abuse would continue. Cydney declined a refuge place and temporary accommodation. Despite this conclusion, the IDVA did not share any information with any other agency even though Cydney was at risk and there may have been a risk to Solomon. At a later time Cydney did apply for local authority accommodation by registering for their Choice Based Lettings Scheme.
- 3.6 Derek saw or had contact with his GP in Coventry on nineteen occasions between June 2008 and June 2011. Eight of those contacts were regarding his mental health, the first being in June 2008 when Derek disclosed depression. The GP was not aware of his marital status and believed him to be single until February 2010.
- 3.7 The GP practice did attempt to get specialist help for Derek in 2010 and 2011. Derek failed to fully engage and despite this the GP continued to refer him to specialist services. This with continued alcohol and drug abuse as well as the violence did not seem to raise any concerns or cause any escalation or alternative approach. Derek was seen by a total of ten GPs from the same practice in a three year period and five different GPs saw him regarding his mental health. However there was little evidence of review/communication or follow up between them. All the communication with the mental health services was by letter and there did not appear to be any attempt at joint working
- 3.8 The GPs who were interviewed as part of this review were unaware that it is no longer appropriate practice to refer perpetrators of domestic abuse for anger management programmes as these programmes do not address the underlying issues and may in fact heighten the risk of harm to victims. The GPs did not inquire with Derek if his wife was pregnant nor did they make any attempt to identify his wife and baby even though they were registered with the same GP medical group albeit at a different surgery.

As a consequence Cydney's GP in both Coventry and Medway were unaware of the assault.

- 3.9 Although there were several referrals by the GP to mental health services there is no documented evidence of reflective consideration in regards to the direct emotional effects of aggression upon Cydney or their baby. The GP surgery in Coventry only shared information with the adult mental health services. The GP surgery was the only agency that knew he had been angry with his wife prior to the assault on the 1st April 2011 and was seeking help. At this time none of the GPs at this surgery had attended the safeguarding children training in Coventry which included an input on domestic abuse.
- 3.10 During the pregnancy and Solomon's short life no concerns were identified by any of the health visiting and midwifery services in Coventry who came into contact with Cydney and Solomon. Although pregnancy is known to be a time when domestic abuse either starts or does not stop, none of the staff involved with the family recorded whether they asked Cydney if she was suffering domestic abuse, even though it has been recognised as good clinical practice to do so.
- 3.11 The mental health services in Coventry received a number of referrals from the GP regarding Derek and saw him twice between February 2010 and June 2011. In addition they spoke to him by telephone on several occasions. Derek was never diagnosed as suffering from any mental illness.
- 3.12 The mental health services appear to have dealt with each of these incidents in isolation and tried to treat each of the symptoms separately e.g. providing information on drug misuse programmes. None of the services involved in treating Derek had the full picture of what had happened as they did not share any information or seek any information other than the contact with children's social care. Therefore none of them were able to fully assess the risk that he posed to his wife and baby. None of the mental health services identified this as being a case of domestic abuse until after the assault in April 2011. In May 2011 the psychological service contacted Coventry Children's Social Care (CSC) regarding Derek as he had disclosed that he had slapped Solomon when he would not stop crying.
- 3.13 Coventry CSC had minimal involvement with the family. They were not known to CSC until the contact by the psychological services. No concerns regarding either Cydney or Solomon were identified by staff at the children's centre where they attended on a regular basis. When the referral and assessment service were contacted by the psychological service they treated the telephone call as a contact they did not record the additional information about the slapping of Solomon and that Derek was

self harming which was included in the written referral from the psychological services. The decision not to pass the information about this family to CSC in Medway is questionable.

- 3.14 The CSC in Medway was never informed that a vulnerable mother and baby had moved into their area. If they had been informed by any of the agencies in Coventry then they would have had the option of commencing an assessment with a view to establishing any risk to Solomon or sharing information with other agencies in Medway such as the Health Visitor and signposting the family to local services.
- 3.15 The GP and Health Visitor in Medway only had contact with Cydney and Solomon once and neither of them was aware of the domestic abuse history. Kent Police and the Kent Fire and Rescue Service only had dealings with the family regarding domestic abuse after the fire.

4 Family involvement in the review

- 4.1 On completion of the trial at the crown court the victim's family was invited to contribute to the review and they provided additional information. On completion of the draft final report the findings were shared with the family and they requested some minor changes which have been incorporated into the report.

5 Key Issues

- 5.1 There was only one recorded incident of domestic abuse reported by Cydney. Her family was aware of some other incidents however she never disclosed the full extent of the abuse to either family, friends or any agency. The abuse continued after the separation.
- 5.2 The failure to share information is a recurring theme in reviews of both domestic homicides and child protection cases that have been carried out nationally. The importance of information sharing is highlighted in most policies and guidance and agencies continually fail to do it and continue to work with the 'rule of optimism'. This review has highlighted the missed opportunities to share information.

6 Conclusions

- 6.1 Based on all of the information that has been made available to this review the panel has concluded there were sufficient indicators available to professionals to conclude that Derek did pose a risk of further assault upon his wife and their baby and more should have been done to protect them. The risk factors that the panel identified were

- The couple had separated
 - Weapons (cans, remote controls, knives) had been used in the past
 - Derek had issues with alcohol and drug misuse
 - Derek had mental ill health issues including self harming
 - Cydney was concerned that Derek may take Solomon
 - Derek was in constant contact with Cydney
 - Derek continued to be abusive after the separation
 - There were financial pressures
- 6.2 A number of agencies possessed some of that information but did not recognise the significance and then share it. The indicators of abuse known to agencies were that Derek had hit his wife on at least one occasion, he had hit his baby at least once, he admitted getting angrier and that the way he dealt with it was by punching items. In addition his alcohol and drug misuse coupled with his low moods and self harming were further indicators of risk. He had little support from his family with only his brother living in the same area. In addition although he sought help he did not actively engage with services other than attending frequent appointments with his GP.
- 6.3 There was no evidence provided to the review panel that indicated that this homicide was based on any cultural or religious beliefs. There was also no evidence of any issues concerning culture, religion, language or ethnicity in the way that the services were provided.
- 6.4 There was evidence of agencies working in accordance with their policies and guidance and providing an appropriate, timely and effective service to both Cydney and Derek such as the West Midlands Police when they dealt with the assault and the IDVA in Medway however that good work was not followed through with effective information sharing.
- 6.5 The lack of information sharing in this case restricted any agency carrying out a full risk assessment of all the information available and therefore they were prevented from making complete risk reduction plans for both Cydney and Solomon.
- 6.6 This review has highlighted the issue of families that move between areas and the difficulties that agencies face in tracking them. In addition some of the agencies and individuals were of the view that because they had separated then the risk to Cydney was reduced, when in fact separation, especially in cases involving child contact arrangements coupled with the distance between them may have actually increased the risk. There is no national policy for the police service regarding notification of victims of domestic abuse who move to another police area other than when a victim is subject to MARAC.

- 6.7 Deaths by arson are relatively rare; in England and Wales in 2010/11 twenty victims were killed by burning out of a total of six hundred and thirty six victims of all homicides. The actual use of fire in domestic abuse is also rare although the threat is more common. There was no information or intelligence held by any agency or any individual that Derek was likely to carry out an arson attack and therefore understandably arson was not specifically included in any of the advice provided by agencies to Cydney.

7 Recommendations

- 7.1 As a consequence of this review some agencies have made single agency recommendations to improve practice, linked to action plans and have been put into place; these are welcomed by the panel. The following recommendations were made by this review:-

- All agencies in Coventry to reassure themselves that staff are accurately recording and sharing information in cases of domestic abuse and in particular where children are resident so that others accessing records can identify the issues and risks as well as seeking specialist advice where appropriate.
- The Clinical Commissioning Group in Coventry responsible for GPs to review and update their guidance to GPs regarding treatment and referrals of perpetrators of domestic abuse and the need to consider the protection of victim's families by appropriate sharing of information. In addition the review should take into account the guidance issued by the RCGP and CAADA in May 2012. **Correction: Since April 2013, Primary Care Services are commissioned by NHS England and not Clinical Commissioning Groups. At the time of the DHR, Coventry Primary Care Trust (PCT) was responsible for commissioning primary care from independent GP practice.**
- The CCG in Coventry responsible for GPs to recommend that GPs review their guidance for all staff regarding their response to patients who threaten to harm themselves or others. The guidance should be that only appropriately trained medical staff should deal with such matters and other agencies such as the police should be involved in the response when necessary. The individual should be seen and the risks assessed and recorded as well as protection plans for anyone identified as being in danger. **Note: Since April 2013, Primary Care Services are commissioned by NHS England and not Clinical Commissioning Groups. At the time of the DHR, Coventry PCT also recommended to GPs that they review their guidance not CCG as stated.**

- The Coventry and Warwickshire NHS Partnership Trust to review and update their guidance to psychological services and adult mental health teams regarding treatment and referrals for patients who they are treating that are perpetrators of domestic abuse. In particular the need to consider the protection of victim's families by appropriate sharing of information with other agencies.
- The West Midlands Police to reassure themselves that staff are aware of the requirement to carry out risk assessments in domestic abuse cases in accordance with their policy.
- West Midlands Police consider reviewing the joint domestic abuse screening process to ensure there are no back logs and that information is recorded accurately by all partners of all decisions made.
- The CAB and Housing Department in Medway to review their policy and guidance regarding sharing of information with each other and other agencies to ensure that full risk assessments take place.
- The Home Office working with other government departments considers developing policy regarding when agencies become aware a victim of domestic abuse has moved from their area to another area and how they should share that information with agencies in the new area.