

Domestic Homicide Review
Elizabeth/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

1.1 This domestic homicide review (DHR) examines the circumstances surrounding the death of Elizabeth between 28th and 29th April 2015. Her husband, Richard, was convicted of manslaughter and sentenced to 15 years imprisonment. This report has been anonymised and all the personal names contained within it, with the exception of members of the review panel, are pseudonyms.

2. The Purpose of the Review

2.1 The purpose of a domestic homicide review as set out in the Multi-Agency Statutory Guidance for the Conduct of a Domestic Homicide Review is:

- 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.
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted upon, and what is expected to change as a result.
- Apply those lessons to service responses including changes to policies and procedures as appropriate.
- Prevent domestic violence homicide and improve services responses for all domestic violence victims and their children through improved intra and inter-agency working.

3. The Review Process

3.1 The review began with an initial meeting held on 18th August 2015. Organisations that attended had indicated that they potentially had relevant contact and/or involvement with any or all of Elizabeth, Richard or their children prior to Elizabeth's death. The Terms of reference as set out below were agreed.

The Purpose of DHR

The purpose of this review is to:

- i. Establish what lessons are to be learned from the death of Elizabeth 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 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 Elizabeth.
- 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.

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, Elizabeth 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 any direct involvement with Elizabeth, 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 Elizabeth from 1st January 2007 to 29th April 2015. If any information relating to Elizabeth victim, or Richard being a perpetrator, of domestic abuse before 1st January 2007 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 Elizabeth or Richard. 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 Elizabeth and Richard, 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 Elizabeth and Richard? 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 Elizabeth and Richard (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 Elizabeth and promote their welfare, or the way it identified, assessed and managed the risks posed by Richard? 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 Elizabeth and Richard?
- xi. To what degree could the death of Elizabeth have been accurately predicted and prevented?

3.2 The following organisations were requested to complete Independent Management reports (IMR's):

- Police
- Health Agencies: General Practitioner (GP), East Kent University Hospitals NHS Foundation Trust (EKUHFT), Kent Community Health NHS Foundation Trust (KCHFT).

3.3 Summary reports containing details of any engagement with family members were requested from the following agencies as their engagement had been determined as minimal:

- Kent County Councils Children's Centres and Social Care.

At a later stage the local school was also requested to provide a report.

Agencies were asked to provide chronological accounts of their interaction with Elizabeth, Richard and their children. The individual management reviews were intended to cover the following:

- A detailed chronology of interaction.
- Whether internal procedures were followed and their impact.
- Analysis, lessons learned, conclusions and recommendations for an agency action plan.

3.4 The time period to be covered by the review process was agreed as January 2007 to April 2015. This covered the duration of the relationship between the victim and the perpetrator with report authors being encouraged to include relevant detail outside of this timeframe where appropriate.

3.5 All agencies submitted the required documentation in a timely and professional manner. Following an initial analysis of the information provided agencies were requested to further review their records to include alternative surnames that had been used during that time period. In addition, the local primary school that the children attended was requested to provide a report covering their interaction with the family.

3.6 The review group membership was as follows:

James Parris	Independent Chair and Overview Report Writer (Independent Consultant)
Bonnie Wyatt	NHS England
Alison Gilmour	Kent & Medway Domestic Abuse Coordinator
Rosetta Lancaster	Ashford & Canterbury Clinical Commissioning Group
Wendy Bennett	Ashford & Canterbury Clinical Commissioning Group
Carol McKeough	Kent County Council Adult Services
Tracy Anstis	Kent Police
Tom Stevenson	Kent County Council Children's Services
Liza Thompson	Swale Action to End Domestic Abuse (SATEDA)
Shafick Peerbux	Kent County Council Community Safety

3.7 The review panel met on the following dates:

- Tuesday 18th August 2015
- Monday 30th November 2015
- Wednesday 13th April 2016
- Thursday 26th May 2016

3.8 The Chair of the Panel and author of the overview report has had no direct involvement with any of the professional's work being reviewed. The author is an independent consultant who has held senior positions in both the public and private sector and was a Senior Community Safety Manager until retiring in March 2015.

4. Background and Summary Chronology

4.1 Elizabeth was born in Poland and in 2004 she relocated to the United Kingdom. Elizabeth had been living with Richard for about eight years and they had been married since July 2013. Approximately two weeks before her death Elizabeth returned to Poland with her children to see her parents. It was there that Elizabeth disclosed to friends that her relationship with Richard was in decline and that she was going to leave and divorce him.

4.2 On the 30th April 2015, Richard reported to the Police that his wife was missing. Elizabeth lived with her husband and their two children, Child A aged 5 and Child B aged 4 years. They had been married for 2 years but had been together for approximately 8 years. Richard told the Police that he and Elizabeth had not been getting on, that she had been out that evening and that when she got home they had had an argument and she stormed out. The call was initially dealt with as a Missing Person Report by Divisional Police Staff carrying out normal missing person enquiries. On the 3rd May 2015, the Missing Person investigation was reclassified as 'High Risk' and Police officers were deployed to conduct a thorough search at the home address and speak to Richard. This re-classification was due to Elizabeth's friends being concerned about a couple of Facebook entries made on the 2nd May 2015 on Elizabeth's Facebook page, which didn't sound like her, but purported to be from her.

4.3 During the 'High Risk' Missing Person search on the 3rd May 2015, Police Officers found traces of blood on a doormat and pets bedding. The Police arrested Richard on suspicion of Grievous Bodily Harm.

- 4.4 It would appear from reports from friends that Elizabeth was not happy with Richard due to his drinking and lack of parental responsibility. It was also reported that he was very controlling and jealous of her. There was also evidence from friends to show that Elizabeth was planning to leave him.
- 4.5 Richard also checked Elizabeth's phone for numbers and who she called and utilised a tracking App on her i-Phone, so he could see where she was at any time. The tracking App was disabled on Elizabeth's phone by a friend on the 27th April 2015. This information started to highlight Richards controlling behaviour towards Elizabeth.
- 4.6 Richard was charged with the murder of Elizabeth on the 7th May 2015. Richard divulged to a family member where Elizabeth body could be found so that it was possible for Police to narrow down their search and discover Elizabeth's body.
- 4.7 Richard was subsequently found guilty of manslaughter and received a 15 year sentence.
- 4.8 In 2011 Police were called by Elizabeth reporting an assault by Richard, this occurred at their then home address. She asked the police not to attend that day but said she would go to the Police Station the following day. The following day, a further report was made by Richard's father that the couple were at home arguing. Police then attended the home address.
- 4.9 Elizabeth informed the attending officers what had happened the night before and this resulted in Richard being arrested for causing Actual Bodily Harm. Elizabeth informed the officers of several other incidents of a similar nature that had not been previously reported to the police. She told the officers that Richard had been drinking to excess. The Crime Report indicates that Elizabeth wished to speak to a member of the Domestic Abuse Team, and that she was frightened when her husband was drunk as he was violent towards her. Kent Police assessed the incident and made suitable referrals to Kent County Council Social Care. Although a letter was sent to the victim which was standard practice at the time, it is acknowledged this may not be the most appropriate or effective way to communicate with victims of domestic abuse. Practice has since changed to improve the service offered to victims and one of these changes is that all victims will receive a phone call from Victim Support. Victim Support will offer wellbeing,

emotional, safety planning and crime prevention advice and will also refer the victim to a community service provider.

- 4.10 Apart from the procedural changes arising from the establishment of the Partnership Central Referral Unit (CRU) the HMIC inspected the Kent Force in 2014 in relation to Domestic Abuse. The HMIC acknowledged that the Force had robust processes in place to ensure that any learning from the DHR process, as well as Serious Case Reviews was highlighted and addressed with any learning being reflected in improvements to frontline policy and procedure. The 2014 report also made fourteen recommendations that were subsequently monitored and implemented leading to significant changes to frontline procedures and policies across the Kent Force. The 2014 HMIC report was linked to a national review of domestic abuse services HMIC “Everyone’s Business”. A number of recommendations in this report relate to service delivery at Force level and these have also been fully implemented. Other major changes to policy and procedure have been delivered by the Force as part of planned operations including the introduction of a domestic abuse victims’ satisfaction survey. One of these being Operation Encompass which is a process where all safeguarding agencies share information about domestic abuse incidents to help protect any children who are involved.
- 4.11 In April 2011, the family was visited by the health visitor following the birth of Child B. Richard was described as being very helpful. A note in the Family Health Needs Assessment stated that ‘a reported incident of domestic violence during pregnancy but mum has Children’s Centre’. This comment would suggest that Elizabeth could access support with the issue of domestic violence from the Children’s Centre.
- 4.12 The family had a number of interactions with health agencies with two notable events. In March 2015, Richard attended his last GP appointment prior to the incident and notes recorded: ‘stress related problem, self-employed which stressful, having problems at home with wife. Wants to go back on Citalopram, declined RELATE for now; have made plans to take wife somewhere so they can speak about their problems. Medication was prescribed (Citalopram) to be taken as required’.
- 4.13 There were only two recorded presentations at the Children’s Centre for generic “stay & play” sessions, which are open sessions which are available to all families in the local community and nothing further was recorded

regarding interaction with the family. The local primary school also reported that they had no recorded issues of concern prior to the incident.

5. Issues arising from the review

- 5.1 Elizabeth was pregnant with her second child at the time of the 2011 incident and the attending police officers categorised the domestic abuse incident as “medium” which was later re-assessed by the supervising officer as “standard” with the child protection issue also being re-categorised as “low” risk. The assessment followed policy that was in place at the time of the incident. The Crown Prosecution Service also decided not to pursue any charges against Richard for the offence of common assault as the allegation was denied, there were no witnesses and no previous bad character was recorded. A referral was made by Police to Kent County Council Social Services in respect of the child and the unborn child.
- 5.2 Following the 2011 incident a social worker met with Elizabeth. The records indicate that Richard was not present and Elizabeth stated that there had been previous arguments but nothing like the incident in question. Elizabeth said she would not allow this to happen again and if necessary she would leave. The assessment concluded that no further action would be taken by Children’s Services and following further agency checks with the General Practitioner and the Midwife the case was recommended for closure.
- 5.3 Since 2012 a multi-agency Central Referral Unit has been established that deals with all Kent County Council Social Care referrals. It consists of the whole range of service providers who are or might be involved with vulnerable children, and with adults in relation of matters of public protection. The Central Referral Unit facilitates more consistent threshold application between agencies, reduces duplication, promotes more effective information sharing and thereby promotes more timely and targeted intervention for children and families. The services are co-located making multi-agency planning and intervention easier, with access to relevant data and systems. The following partners are engaged: Children Services, Police, Adult Services, Kent Surrey & Sussex Community Rehabilitation Company, National Probation Service and Health Agencies.
- 5.4 Health organisations work to the current Kent and Medway Domestic abuse protocols and it is evident that they have followed standard practice and procedures to support identification and prevention of domestic abuse.

Elizabeth did not disclose any relationship issues of concern with Richard. However, for all organisations the culture of questioning around domestic circumstances could be sharpened to determine levels of risk or safety. It is possible that if the incident of 2011 was reported / recorded in the GP's notes, a more holistic response may be taken to the stress factors which Richard later disclosed. During the review, it was confirmed that Health Visitors are now informed of Domestic Abuse Notifications (DAN's). These tend to be low level DAN incidents only, with higher risk incidents being open to early intervention or the MARAC process. Where there is an unborn child in the family or a baby under one year, it is normal practice to inform Midwives as well. In terms of information sharing with the General Practitioner this is currently generally limited to the MARAC process. Although there is now a CCG Safeguarding General Practitioner lead in place it is felt that this area of information sharing across health practitioners should be strengthened and a recommendation is included in the report at paragraph 7.1.

- 5.5 The lack of engagement with family members, friends and colleagues during this review has lessened the opportunities to determine if Elizabeth was searching for domestic abuse support services and for the opportunity for disclosing her situation to agencies. The local Polish Association were contacted and their website did have details of a domestic abuse helpline but no records were kept of referrals. The interview with Elizabeth's friend indicated that Elizabeth would not have sought help and was focussed upon making arrangements herself for her own safety and the safety of her children. However, she did have contacts with the Police, Health Agencies and a Children's Centre who could have signposted support services, but it would appear that Elizabeth did not make any disclosure or requests for assistance apart from the 2011 incident when Elizabeth requested contact from the Police Domestic Abuse Team.
- 5.6 There is no evidence to suggest that Elizabeth's Polish family connections had any impact on her ability to seek support for the domestic abuse she was experiencing in her relationship.

6. Overall conclusions

- 6.1 The re-assessment of the 2011 incident as a "standard" risk domestic abuse incident despite the arrest for an offence of Actual Bodily Harm together with the decision to write to Elizabeth offering support could be considered as a

lost opportunity for Elizabeth to engage with some form of support service. However, since 2011 the domestic abuse policy and practices have changed significantly and bare little comparison to the time of the incident in 2011, (see paragraph 4.9 and 4.10). All domestic abuse victims are now referred to Victim Support where they are offered wellbeing, emotional, safety planning and crime prevention support and are also referred to a community service provider.

- 6.2 A referral was made to Kent County Council Social Services by Police following the incident in 2011. There was a degree of information sharing between Kent County Council Social Services and Health partners following the 2011 incident, but it does not appear that this information was communicated to all those agency staff engaging directly with Elizabeth. It is noted that the referral process was reorganised in 2012 and referrals are dealt with now by a multi-agency central referral unit. However, it was felt that there was still some room for improvement in this area and a recommendation has been included relating to information sharing across front line health workers and General Practitioners.
- 6.3 The Health Visitor was unable to discuss domestic abuse with Elizabeth at her initial visit and it is not clear whether the discussion took place at a future visit. This also suggests that the process of information dissemination could be improved. A further recommendation is also included relating to reminding health professionals about the importance of clear and accurate record keeping aimed at improving the quality of information sharing.
- 6.4 Elizabeth had engagement with only a few agencies as a domestic abuse victim through her contact with the police and other than the police letter there is no evidence that any support services were signposted for her. She also came into contact with agencies through routine contacts relating to children's health care, general practitioner visits and Children Centre attendance and these could have been prime communication sites for domestic abuse support services if she was looking for support.
- 6.5 Richard was utilising a Tracking App on Elizabeth's mobile telephone without her knowledge which was subsequently disabled by a friend. This use of covert surveillance of adults should be considered as a form of stalking and highlighted by domestic abuse support services and should be highlighted to the wider community as these App's are often routinely installed on mobile telephones and a recommendation is included relating to this area.

- 6.6 All health domestic violence and abuse training should include how to have difficult and sensitive conversations on the subject with patients and training is currently being rolled out across Kent and Medway relating to Safe Enquiries and is available in an eLearning format www.kdac.org.uk/health-professionals
- 6.7 There is a continuing need to ensure that communities are aware of the domestic abuse services available to them and given the changes being planned for domestic abuse service delivery in the area where the incident took place it is vital that the promotion of services reflects the make-up of the local community and where necessary there is consideration given to providing support material in alternative languages.

7. Recommendations

- 7.1 Consideration to be given to widening the communication of personal information in relation to domestic abuse incidents following referrals from Social Services to all frontline health workers/agencies and relevant GP's that have direct contact with the victim. This will ensure that frontline health staff including General Practitioners are fully briefed when engaging with potential victims or perpetrators and can signpost appropriate support services and provide opportunities for disclosure during consultations.
- 7.2 Ensure that all Kent County Council Children's Centres display domestic abuse support services information and that staff are able to signpost to local services. This will enable those victims that feel unable to disclose their personal circumstances to be better informed of the support available.
- 7.3 Given the changes to the ethnic make-up of communities in the area concerned consideration should be given by the local Community Safety Partnership and Local Domestic Abuse Forums to providing domestic abuse support material in alternative language formats, therefore responding to the changing demographics in their area.
- 7.4 In liaison with domestic abuse support providers raise the awareness of the potential misuse of Tracking Apps that are routinely installed on mobile telephones and other devices with potential victims and service providers, the focus to be particularly in terms of Stalking and Harassment. The Kent County Community Safety Partnership to raise the profile of this subject at the Kent and Medway Domestic Homicide Review Lessons Learnt Seminars and at Community Safety Managers Information sessions.

7.5 Health Practitioners should be reminded of the importance of clear and accurate notes in record keeping. This will assist information sharing between the various front line health professionals. This recommendation should be reinforced as part of the wider information sharing recommended in recommendation 7.1.

Appendix A - Glossary

Abbreviation	Description
DASH	Domestic Abuse, Stalking and Harassment and Honour Based Violence risk assessment
IMRs	Independent Management Reports
EKUHFT	East Kent University Hospitals Foundation Trust
KCHFT	Kent Community Health Foundation Trust
GENESIS Database	This is a name for the IT System used by Police to create and store crime reports, secondary incident reports and criminal intelligence
STORM Records	This is the name of the IT System used by Police to manage incidents. STORM records all information received and actions taken in response to a call.
PNC	Police National Computer system
DNA profiling	The analysis of a small amount of genetic material from a blood or cellular sample, which is unique per individual as a fingerprint
DAU	Police Domestic Abuse Unit
CAIU	Child Abuse Investigation Unit
MARAC	Multi-Agency Risk Assessment Conference
RELATE	Organisation providing relationship counselling.
GP	General Practitioner
A&E	Accident & Emergency
SENCo	Special Educational Needs Coordinator
Children's Centre	The purpose of a children's centre is improving outcomes for young children and their families, with a particular focus on the most disadvantaged families in order to reduce inequalities.
DAN	Domestic Abuse Notification when a child is present when a Police Officer attends a domestic abuse incident.

<p>OP Encompass</p>	<p>Operation Encompass is a process where Kent safeguarding agencies share information about domestic abuse incidents to help protect any children involved.</p>
<p>CRU</p>	<p>Central Referral Unit – It consists of a range of statutory agencies who are or might be involved with vulnerable children, and with adults in relation of matters of public protection.</p>