safe & sound
Dudley's Community Safety Partnership

Executive Summary

of the Domestic Homicide Review

under section 9 of the Domestic Violence Crime and Victims Act 2004

In respect of the death of a woman

In January 2018

Report produced for Dudley Community Safety Partnership by
Paula Harding
Independent Chair and Author
July 2019, revised July 2020

Contents

1. Introduction

1.1 This domestic homicide review concerns the death of a forty-four-year-old woman who was the mother of eight children and who was brutally killed by her fifty-year-old partner when she was trying to leave him in January 2018. Hereinafter, the woman will be referred to as the victim and her partner, the perpetrator.

1.2 The perpetrator strangled and killed the victim and then tried to hide her body. He was convicted of manslaughter and received a fifteen-year sentence and it was ordered that he would be monitored for five years longer than normal on release.

2. Summary of the review process

2.1 The decision to hold a domestic homicide review in this case was made by the chair of Dudley's Community Safety Partnership on 23.02.2018, in consultation with partner agencies, and the Home Office was notified on the same day. The review was managed in accordance with the relevant statutory guidance and the Partnership endorsed the report on 29.07.2019 prior to submission to the Home Office.

2.2 The review panel met on four occasions. Panel members are listed in Appendix A and had no prior involvement with the family. The terms of reference were developed by the review panel and incorporated key lines of enquiry and specific questions for individual agencies where necessary, as featured in Appendix B. Agencies participating in the review are featured in Appendix C as well as those who had no contact. Agency reports were authored by professionals who had not had any direct contact or management involvement with the victim or her family.

2.3 The victim's surviving family were contacted at suitable intervals during the review, but they did not respond and therefore were deemed to have declined involvement.

2.4 The Independent Chair and Overview Author is Paula Harding who has over twenty-five years' experience of working in domestic violence with both senior local authority management and specialist domestic violence sector experience. She was independent of both the Community Safety Partnership and any organisations involved in providing services to the family.

3. Sequence of events

3.1 The victim had a long history of domestic violence and sexual abuse before she met the perpetrator and had started drinking at the age of fourteen in order to deal with these experiences. Her drinking and drug taking went on to escalate over the course of her life.

3.2 It appears that she met the perpetrator during 2013, shortly after he had been released from prison. He had subjected his ex-partner to abuse throughout their

relationship and continued to stalk and harass her after the relationship ended to such a degree that his victim was presented to MARAC.

3.3 In 2013, the victim first disclosed to primary care that she was experiencing domestic abuse from her ex-partner and was struggling with depression and anxiety and had a long history of substance misuse. She went on to make her first report to the police about the perpetrator's domestic abuse, in 2014.

3.4 In 2014, the local authority landlord took court proceedings to evict the victim as a result of many problems with the tenancy including rent arrears, nuisance and neglect of the property and she went on to stay with friends until further accommodation could be found.

3.5 In the coming months, the police received a number of complaints regarding the victim's anti-social and aggressive behaviour whilst intoxicated and such reports were repeated over the coming years. At the same time, the victim reported significant domestic abuse from the perpetrator. As well as seriously assaulting her, he had threatened that he would have killed her but did not know what to do with the body. The police assessed her as high risk and were successful in challenging the Crown Prosecution Service's decision not to charge him, although the case was eventually dropped when the victim withdrew her statement.

3.6 On the recommendation of the police, the victim attended the Emergency Department to have her injuries assessed. She disclosed her experience of domestic abuse and how the perpetrator had prevented her reporting abuse by locking her in. There was no evidence that the hospital checked these details with children's services or provided the victim with sources of support for domestic abuse.

3.7 The police referred her to the MARAC where the actions arising were not meaningfully progressed: Adult Social Care delayed two months in responding but then had been given the wrong contact details; no referral was undertaken by the Police to substance misuse treatment services.

3.8 The victim did not report domestic abuse to the police for eighteen months after this time although she continued to make disclosures to primary care services about the domestic abuse, her long history of depression, drug and alcohol abuse and her own violence to her partner. She wondered whether she was Bi-Polar or had a personality disorder but did not engage with psychology service appointments that were made for her. This pattern of seeking help but not attending follow-up appointments meant that the victim was never effectively treated for her mental health and substance misuse concerns.

3.9 Following six reported incidents over the next six months, the victim was referred again to the MARAC in December 2016, but agencies were again unable to effectively engage with her.

3.10 The victim went on to report domestic abuse a further four times before her death. At one point, she contacted the police to say that she was going to stab the perpetrator herself but later denied that she intended to harm him. Whilst the police were aware of his threats to kill her on three occasions, many of the reports involved both parties being intoxicated and the circumstances were far from clear. This often frustrated police officer's attempts to take the necessary statements and determine whether offences had been committed. Of the twelve reports of domestic abuse, DASH was only completed three times, as it was not mandatory at the time, and there was a varied understanding of the risk that she faced. Not every report was identified as domestic abuse or recorded in the way it should have been.

3.11 In May 2017, the victim told her GP that she had recently ended an abusive relationship and that she had moved out of home because there was a risk that her abusive partner may return. Later in the month she said that her ex-partner was harassing her by walking back and forth outside her home and there was no restraining order in place. Subsequent attempts to refer her to mental health services were thwarted when a man answered the phone to the Community Psychiatric Nurse and in the absence of other means of contact the nurse referred her back to the GP.

3.12 The victim's last contact with agencies was in September 2017 when she contacted the police as she could not get the perpetrator, who was extremely intoxicated, to leave her home. The perpetrator was removed and taken to his mother's address, but officers used their discretion not to complete a DASH and the level of risk was recorded as standard on the basis that it was a verbal argument and that the perpetrator had been removed.

3.13 After killing the victim in January 2018, the perpetrator was assessed by mental health practitioners whilst in police custody and there was no evidence of psychosis, thought disorder or paranoia.

4. Key Issues and Lessons to be Learnt

Domestic abuse and coercive control

4.1 The review has revealed that the perpetrator subjected the victim to:

- physical violence, whereby the perpetrator had punched and kicked her and put his hands around her throat
- threats to kill, whereby she alleged that the perpetrator said that he would have killed her but didn't know what to do with body; she alleged that he had laid a hammer and knives out saying that he had got them ready for her
- intimidating behaviour, whereby he admitted to having cut up her clothes and urinated on her papers
- financial abuse, whereby he demanded, with menaces, money for alcohol
- restricting her movements, whereby she had to use the opportunity of going out for food to phone for help
- stalking
- undermining her credibility and making counter-allegations
- the greatest risk when she was trying to separate from him

4.2 In response, the victim blamed herself and thought she had a serious mental health issue. Although she had been violent to others, agencies did not question whether this self-perception was a consequence of the perpetrator's coercive control and manipulation.

Learning points: domestic abuse and coercive control

- A perpetrator's history of violence and stalking must inform future assessments of risk
- Perpetrators of domestic abuse will often manipulate their victims and lead them to believe that they are responsible for provoking the abuse and make them doubt their sanity through relentless emotional abuse and coercive control. Perpetrators of domestic abuse will also manipulate professionals in an attempt to discredit their victims and draw attention away from their own abusive behaviour.
- Stalking behaviour has featured in the vast majority of domestic homicides. Although the behaviour need not appear serious, it should always be an indicator of high risk.
- Separating from a domestic abuse perpetrator is the most dangerous time for victims and children and agencies should work with the victim to strengthen their safety plans at this time rather than assume that separation will lead to safety.

The 'Right to Know'

4.3 There was some disagreement within the review panel about whether the perpetrator's violent history should have been disclosed to the victim, as he had not been convicted of violent offences, although he was known at MARAC to present a high-risk threat to another woman, two years earlier. For some, this would have been disproportionate for the purposes of preventing crime. For others, his pattern of violence and stalking behaviours were important information to share with the victim because of the risk that he then posed.

Learning Point: Domestic Violence Disclosure Scheme.

4.4 In certain circumstances, domestic abuse victims may have both a 'right to ask' and a 'right to know' about their abuser's violent history and all agencies need to be alert to these possibilities when working with victims of domestic violence and abuse.

Domestic Abuse, Substance Abuse and Mental Health

4.5 The victim had experienced the compounding effect of repeated and sustained domestic and sexual violence and abuse and this had an impact upon her mental health and her substance misuse. The victim had been relatively open with health professionals about prior experiences of abuse but there was little in the way of routine enquiry regarding her current vulnerability to abuse, particularly in the light of her mental health and alcohol concerns.

4.6 Appropriate and sensitive routine enquiry must be standard practice across all services that women with experience of abuse come in to contact with and it was reassuring to the panel to see the improvements that were already being made in this regard for mental health services, GP services and the Emergency Department in the area. The introduction of the IRIS scheme into GP Practices, the introduction of an Independent Domestic Violence Advisor into the Emergency Department and mandatory training for mental health practitioners were seen as particularly positive.

4.7 Agencies struggled to meaningfully engage the victim who often declined the offer of services or did not engage beyond the first contact which is not unusual for women experiencing the compounding effects of multiple disadvantage. However, she appeared most comfortable making disclosures to the GP and to primary mental health workers and, had the domestic abuse worker been able to take a direct referral from primary care as happens under the IRIS scheme, then this pathway may well have felt timelier for the victim, at the point where she felt able to disclose her experiences and seek help.

4.8 The report highlights recent recommendations from the Women's Mental Health Taskforce which have identified the need for all services to be both trauma and gender informed. Although there are local initiatives in Dudley currently looking at

trauma informed practice and the adoption of the ACES model, being only trauma-informed without being gender-informed would not necessarily have helped the victim in this case. She needed agencies to understand the compounding effect of different forms of male violence against her throughout most of her life and how these led to her vulnerability to abusers, to her self-blame and most likely contributed to her mental ill-health and substance misuse.

Holding Perpetrators to Account

4.9 We have already seen that the perpetrator had a history of violence and was known to be a high-risk perpetrator of domestic abuse but it was not evident that this history was informing agencies' assessment of his threat to the victim thereafter.

Learning Point: all agencies need to appreciate the impact that a perpetrator's abusive history should have on assessments of risk to subsequent victims.

4.10 Although the circumstances facing the police response were often far from clear, the absence of DASH assessments and the failure to record domestic abuse as a 'non-crime' meant that there were opportunities missed for a supervisor to review the circumstances holistically. There was also an absence of referrals to specialist domestic abuse and treatment agencies. It has been recommended that the police evidence the improvements that have taken place since this time.

Multi-Agency Risk Assessment Conference

4.11 The victim was referred to MARAC twice , but the responses from MARAC were inadequate: there was an inadequate method of monitoring these actions and holding agencies accountable; Adult Social Care displayed a lack of urgency in responding; GPs were not engaged with MARAC; the recording practices of some agencies made it difficult for them to identify their service users who were already known to be facing high risk and the IDVA service was unable to engage with the victim meaning the victim's voice and safety planning was not considered.

4.12 Much has improved in the management arrangements for MARAC in Dudley since this time and it is therefore recommended that the local area seeks evidence of the impact of these changes.

5. Recommendations

5.1 Overview Recommendations

Recommendation 1: Understanding Domestic Abuse
Dudley Safe and Sound should review and seek assurance about the degree to which agencies support front-line staff and their supervisors to understand this breadth and range of domestic abuse, coercive control and stalking behaviours as well as identify and respond to risk.

Recommendation 2: Raise public awareness
Dudley Safe and Sound should continue to raise public awareness specifically about domestic abuse, coercive control, stalking and harassment

Recommendation 3: Domestic Violence Disclosure Scheme
Dudley Safe and Sound should ensure that the Domestic Violence Disclosure Scheme is well known by agencies and the public alike.

Recommendation 4: Trauma and Gender Informed Services
Dudley Safe and Sound and Safeguarding Boards should seek assurance from agencies that services and pathways are trauma-and-gender informed and flexible enough to effectively engage with women facing multiple disadvantage, using the West Midlands Domestic Violence Standards and the trauma-and-gender informed principles of the national Women's Taskforce on Mental Health as guides.

Recommendation 5: Enabling Engagement with Specialist Services
Black Country Women's Aid to provide evidence of effective interventions and engagement methodology for victims who present with multiple and complex issues that may have resulted in them disengaging from other services.

Recommendation 6: Perpetrator's History of Violence
Dudley Safe and Sound should seek assurance from its agencies that they are able to accurately record and access records on an abuser's previous violent history and apply this to current risk assessments and responses.

Recommendation 7: Policing Domestic Abuse
West Midlands Police should provide evidence of the improvements made in the policing of domestic abuse to Dudley Safe and Sound, particularly compliance and impact of the changes concerning: the mandatory completion of DASH; referrals to specialist domestic abuse and alcohol treatment agencies, and the impact of portable mobile devices.

Recommendation 8: Adult Social Care response to high risk victims of domestic abuse

Adult Social Care should provide evidence of how it has improved its response to MARAC and achieved outcomes for domestic abuse victims in the following areas:

- Prioritisation of MARAC cases and workload capacity of staff enabling an urgent response
- Co-terminosity between Multi-Agency Safeguarding Hub and MARAC
- Effective communication between Adult Social Care MARAC representative and allocated social workers
- Effective internal escalation and feedback to MARAC when task cannot be fulfilled
- Effective working relationships with IDVA service

Recommendation 9: MARAC

Dudley Safe and Sound should consult with the Office of the Police and Crime Commissioner and evidence how the recent improvements to MARAC arrangements have impacted upon agency involvement, victim safety and holding perpetrators to account.

5.2 Individual Agency Recommendations

Recommendations for Dudley Group NHS Foundation Trust

Recommendation 1: Funding to be secured for an Independent Domestic Violence Advocate in the Emergency Department.

Recommendation 2: Continue to work toward meeting the NICE Quality Standard on Domestic Violence and Abuse QS116

Recommendation 3: Domestic abuse training to continue to emphasise the connection between domestic abuse and substance misuse.

Recommendation 4: Emergency Department staff to receive bespoke training in regard to alcohol misuse and local services available to give advice and support.

Recommendation 5: Safeguarding training to continue to discuss self-neglect and possible indicators.

Recommendations for Dudley and Walsall Mental Health Partnership NHS Trust

Recommendation 1: To ensure that all professionals continue to access the safeguarding practitioners for advice and that they play a key role in the early identification and response to domestic abuse and coercive and controlling behaviour.

Recommendation 2: To ensure that all staff complete their mandatory domestic abuse training and for the Safeguarding Team to promote and encourage staff to attend external training sessions.

Recommendation 3: To identify themed DHR case studies to be included in the safeguarding newsletters, domestic abuse training and bulletins which are circulated to all Trust staff.

Recommendation 4: For the Trust to develop the of Top 10 Safeguarding Tips which will support staff in their day to day practice by sharing key learning points.

Recommendation 5: As an area of good practice, the Trust will ensure that staff are alert to non-verbal behaviours and be encouraged to collate a genogram to understand the family network. This is following compilation of the combined agency chronology as it is now evident that both the victim and perpetrator had troubled childhoods and they both experienced stressful or traumatic events, including physical and sexual abuse. Children raised in environments where violence, assault and abuse are common will often come to believe this behaviour is normal and therefore find it difficult to establish and maintain healthy relationships. These ACEs (Adverse Childhood Experiences) are strongly related to the development and prevalence of a wide range of health problems throughout a person's lifespan and overtime could have contributed to them both developing negative coping mechanisms.

Recommendations for Dudley Clinical Commissioning Group

Recommendation 1: Monitor the impact of the IRIS Programme within primary care

Recommendation 2: Continue to work to meet NICE Quality Standard on Domestic Violence and Abuse

Recommendation 3: Domestic abuse training to emphasise the importance of 'asking the question'

Recommendation 4: Raise awareness of domestic abuse, National Centre for Domestic Violence and stalking amongst professionals and patients

6. Conclusion

6.1 The victim had experienced male violence for most of her life and suffered those life experiences that are often seen as the consequences of abuse including substance

misuse, mental ill-health, a period of homelessness and her children being removed from her care. Her experience of domestic abuse from her partner, the perpetrator, was wide ranging and she was referred to MARAC twice. She often blamed herself for the violence that she was experiencing and there was insufficient challenge when she articulated these concerns. There were also missed opportunities to disclose the perpetrator's violent history to her under the Domestic Violence Disclosure Scheme which could have helped her to reconsider her self-blame.

6.2 The perpetrator had a history of violence to others and had posed a high risk to his previous partner, but this history of high risk was not always taken into account in future risk assessments and at times, it was observed that an incident-based rather than a holistic approach to risk had been followed. The absence of witness statements which were sometimes declined and sometimes withdrawn, together with the absence of other evidence, meant that the perpetrator was not held accountable for his violence and abuse.

6.3 The review has seen that Dudley can demonstrate many improvements in its co-ordinated response to domestic abuse since agencies' involvement with the victim: West Midlands Police have made completion of the DASH mandatory, in line with national expectations and improved their manner of referrals to other agencies; the MARAC has been resourced and organised at the regional level; mental health services have made domestic abuse training mandatory and both GPs and the Emergency Department will have training and pathways to Independent Domestic Violence Advisors. Each of these improvements in agency responses would have been beneficial to the victim in this case. Nonetheless, victim engagement is critical.

6.4 Agencies experienced difficulties engaging with the victim to complete the DASH; to assist with prosecutions of the perpetrator; to provide mental health services or to refer her to specialist domestic abuse or substance treatment agencies. Their engagement was often hindered because of her inebriation and the times when she did seek engagement with mental health services were often short-lived. It was noted that the introduction of the IRIS programme approach in primary care would have been of particular benefit to victim as it was here that she most readily sought help. Likewise, applying a trauma-and-gender-informed approach, as recommended by the Women's Mental Health Taskforce could help all agencies to improve their engagement with victims who face multiple disadvantage.

Appendix A: Review Panel Members

Name	Designation	Organisation
Paula Harding	Independent Chair	-
Cate Webb-Jones	Adult Abuse Detective Inspector	West Midlands Police (Western region)
Christine Emery	Team Leader	Change, Grow, Live (CGL)
Christina Rogers	Head of Safeguarding	Dudley Group NHS Foundation Trust
Howard Wolfenden	Head of Safeguarding and Review	Dudley MBC Children's Social Care
Jamie Gutteridge	Team Manager, Tenancy Management	Dudley MBC Housing Services
Jane Atkinson	Designated Nurse for Adult Safeguarding	Dudley Clinical Commissioning Group
Katriona Lafferty	Community Safety Officer – Reducing Vulnerability	Dudley MBC Community Safety
Raj Lagan	Regional Head of Domestic Abuse Service	Black Country Women's Aid
Sharon Latham	Head of Safeguarding	Dudley and Walsall Mental Health Partnership NHS Trust
Sue Haywood	Head of Community Safety	Dudley MBC Community Safety

Appendix B: Terms of Reference

The review should consider agencies contact with the victim and perpetrator and should focus on events from January 2012, when the perpetrator's domestic abuse towards his former partner was considered at MARAC alongside his conviction for possession of a knife, until the victim's death in 2018. The review should also consider relevant information relating to agencies' contact outside that time frame for contextual purposes. The timeframe will be extended for the National Probation Service to January 2011 to enable the perpetrator's eighteen-month suspended sentence for an unrelated offence to be considered within the review.

The review sought to address both the 'circumstances of a particular concern' set out in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016). In particular, the review sought:

- To establish what contact that agencies had with the victim and the perpetrator; what services were provided, individually and in partnership; and whether these services were appropriate, timely and effective?
- To establish whether agencies knew, or could have known, about domestic abuse and what actions they took to safeguard and meet the needs of the victim and manage the threat from perpetrator.
- To consider how issues of mental health and substance misuse or any other issues of diversity impacted upon the delivery of services and whether needs or risk arising from these factors were addressed.
- To establish how well-equipped staff were in responding to the needs, threat or risk identified for the family through policies and procedures; management and supervision; training; capacity and resources to meet expected standards of practice.
- To establish what lessons can be learned from the case about the way in which professionals and organisations carried out their duties and responsibilities.
- To identify clearly what those lessons are, how (and within what timescales) they will be acted upon and what is expected to change as a result through the production of a multi-agency action plan
- To recommend to organisations any appropriate changes to such policies and procedures as may be considered appropriate in the light of this review

Additional questions for specific agencies:

Adult Services

- To provide the rationale for transferring the case to the 'Adults at Risk' team following the Multi-Agency Risk Assessment Conference (MARAC) referral and account for the delay in allocating the case.
- To specify which properties that the victim was thought to be living at.
- To consider whether the procedure for closing cases was followed; whether there was an escalation procedure following non-engagement and its relationship with the MARAC process.

Clinical Commissioning Group:

- How the GP records names of partners when domestic abuse is recorded with them?
- What notifications were received from the Emergency Department and how were they acted upon?

Dudley Group NHS Foundation Trust

- To consider how disclosure of domestic abuse were acted upon
- To consider whether there were opportunities to ask about domestic abuse when not disclosed by the victim.
- To consider whether there was sufficient professional curiosity to enquire about where the children lived.

West Midlands Ambulance Service

- To describe the assessment criteria and processes

West Midlands Police

- To provide a contextual summary of the victim's known experiences of domestic abuse prior to the dates in this TOR
- What immediate safeguarding actions were made for the victim when the perpetrator was removed each time?
- Were any referrals made for either the victim or offender in response to reported crimes, or not crimed (non-crimed), incidents?
- How much information about individual's prior history was made available to officers attending each incident?
- How was the victim dealt with when she disclosed that she was the violent one and provoked violence? Were her claims of undergoing diagnosis for Bi-Polar checked and what was the follow-up to this incident?

Black Country Women's Aid

- To provide an analysis of how the service sought to engage with the victim and actions taken when they were unable to engage.

Children's Services

- To provide an information report featuring the dates of child protection proceedings for youngest children and how domestic abuse featured in the assessment of the parenting capacity of their father.

Dudley MBC Housing Services

- What was the nature of homeless prevention and assessment undertaken prior to the eviction in July 2014
- To provide a brief summary about the problems that the victim was known to be having in her tenancy prior to 2014
- To provide a summary of the circumstances through which the victim was known to be a 'Potentially Violent Person' and the processes involved for staff once a tenant has been described as such.

National Probation Service

- To provide a summary of the pre-sentence report completed on the offender in January 2012
- To identify whether there were any opportunities for intervention with the offender on his violence to others

The review will give due consideration to individual vulnerabilities alongside each of the protected characteristics under Section 149 of the Equality Act 2010. In particular, race and ethnicity, sex and gendered violence, as well as vulnerabilities through mental ill-health and substance misuse, are relevant and will be addressed in the commentary and analysis of the review

Appendix C: Agency Involvement

An IMR and comprehensive chronology was provided by the following organisations:

- Dudley Group NHS Foundation Trust (hospital provider)
- Dudley and Walsall Mental Health Partnership Trust
- Dudley MBC Adult Social Care
- Clinical Commissioning Group
- West Midlands Police

In view of their more limited contact, chronology and or information reports were requested from:

- Black Country Women's Aid
- Dudley Metropolitan Borough Council Housing Services
- Dudley Metropolitan Borough Council Children's Social Care
- National Probation Service

All reports were authored by professionals who had not had any direct contact or management involvement with the victim.

The following agencies were contacted but confirmed that the couple had not been known to them or that their contact was not relevant to this review:

- CGL (addiction services)
- CHADD (local domestic abuse services and refuge provider)
- Staffordshire and West Midlands Community Rehabilitation Company