DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

Report into the death of Julie in July 2018

Report produced for East Sussex Safer Communities Partnership by

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Executive Summary

1. Background

1.1 This review has considered the nature of the domestic violence and abuse that was perpetrated against a 47-year-old woman by her extremely violent partner, and the nature of the agencies' responses over the twenty-eight months before her death. In order to protect the anonymity of the victim and her family, the victim will hereinafter be referred to with the pseudonym 'Julie'.

2. Summary of the Review Process

2.1 The decision to undertake a domestic homicide review was made by the Chair of East Sussex Safer Communities Partnership and the Home Office was notified of the decision on 29th October 2018. An independent chair and review panel were appointed, and the review was managed in accordance with the relevant statutory guidance.

2.2 The review panel members are listed in Appendix A and included representation from Change Grow Live (CGL) who provide both domestic abuse and substance misuse services in the local area. They were able therefore to add a specialist perspective on domestic abuse as well as expertise on substance use, which was an important feature of this review. The panel members were all independent of the particular case.

2.3 The process began with an initial meeting of the review panel in April 2019. Terms of reference were drawn up and incorporated key lines of enquiry as featured in Appendix B. Agencies participating in this review are featured in Appendix C as well as those who had no contact.

2.4 The review panel met on three occasions and the Independent Chair contacted family and friends. Family members contributed to the terms of reference and considered the draft Overview Report and their comments have been incorporated.

2.5 The Overview Report was endorsed by East Sussex Safer Communities Partnership in November 2020, before being submitted to the Home Office for approval.

3. Key Findings

3.1. Understanding domestic violence and abuse

3.1.0. The perpetrator had an had an extensive history of serious violent offending, substance misuse and mental illness, for which he received mental health services. He also had a history of domestic abuse, attempting and threatening to smother suffocate his previous partner. He went on to kill Julie by smothering her.

3.1.1. Julie reported domestic violence and abuse to the police on a number of occasions and by October 2017 was considered by agencies at a Multi-Agency Risk Assessment Conference to be at serious risk of harm or death. Some agencies were aware that the perpetrator had tried to strangle and smother her and threatened to kill her. Earlier indicators of high-risk including animal abuse were not identified as such and the police did not recognise Julie's high risk until she had reported domestic abuse a number of times.

3.1.2. Some agencies were also made aware that Julie had become isolated from family and friends, experienced mental illness and substance use and had rent arrears and debt: indicators of domestic abuse, coercive control and economic abuse. However, agencies will not have known that her isolation represented a significant change in her lived experience as she had formerly been a highly gregarious individual. Since starting a relationship with the perpetrator, Julie experienced a marked difference in her life: she became less stable; no longer worked; relied on welfare benefits and was often short of money.

3.2. Routine enquiry

3.2.0. Julie sought medical treatment and disclosed domestic abuse on a number of occasions, but this did not lead to discussion and safety planning around the abuse that she was experiencing. Other indicators of domestic abuse were missed in most health settings.

3.2.1. The review recognised that health professionals have a privileged position in identifying potential domestic abuse. The National Institute for Health and Clinical Excellence provides a list of evidence-based health markers that are indicators of abuse including injuries, depression, sleep disturbance and alcohol use (NICE,2016). Appropriate and sensitive routine enquiry must be standard practice across all services that women with experience of abuse come in to contact with

3.3. Domestic Violence Disclosure Scheme

3.3.0. There was no evidence that Julie was fully aware of the perpetrator's violent past but, aside from Sussex Partnership, no agency appeared to recognise the need to disclose this to her. Julie mostly disclosed her partner's abuse in the context of his deteriorating mental health. Had she known about the previous conviction for domestic violence, she may have been able to consider the particular risks to herself and her family more fully. The review considered that all practitioners need to be alert to the benefits and opportunities provided by the Domestic Violence Disclosure Scheme when any concerns about risk to others arise.

3.4. MARAC

3.4.0. After initial delays and a minimisation of risk by the police, the MARAC shared significant information and utilised a range of actions to protect Julie. However, securing Julie's engagement was critical and more could have been done by the IDVA to try to engage her.

3.4.1. The MARAC was reasonably well attended but lacked key representation from mental health services and the relevant social housing provider. Actions assigned to the probation officer, as lead professional for the perpetrator, were not undertaken and an opportunity missed to alert mental health services of the need to assess the perpetrator's mental health. However, more pro-active management of the perpetrator was needed to manage the threat that he posed.

3.5. Managing the threat from the perpetrator

3.5.0. There seemed no doubt for most agencies that the perpetrator was a very violent man, and the police demonstrated good practice at the outset by recognising that his random violence to others inferred a threat to his partner and they visited her twice to offer support. However, the perpetrator's history of violence and abuse did not always inform agencies' risk assessments concerning the threat that he posed to Julie.

3.5.1. Whilst information about his history of violent offending was available to the police from the outset, risk assessments minimised the risk to Julie who should have been considered high risk from the outset. On one occasion, the police downgraded the risk in an administrative error. For mental health services, the perpetrator's violence was more often considered in the context of deterioration of his mental health and non-compliance with medication rather than in the context of domestic abuse and a specific risk assessment for violent forensic patients was not completed upon discharge from hospital to guide the community teams thereafter. Risk assessments undertaken by probation services were insufficient. They failed to incorporate police and MARAC information and the perpetrator's mental illness and substance were not addressed as triggers for his re-offending. Whilst on supervision, his licence conditions did not feature the requirements to engage with both mental health and substance use treatment. In this way, several agencies failed to effectively assess risk and work in partnership to manage the perpetrator's threat.

3.5.2. At the MARAC, there was evidence of good information sharing but there were other times when information sharing was lacking. For example, the police did not notify probation services when the perpetrator held a knife to Julie's daughters throat. As he was under licence, probation services had powers to warn or recall the perpetrator. The Single Combined Assessment of Risk (SCARF) was not always submitted to Adult Social Care and the Portal Domestic Abuse Service because risk had been minimised.

3.5.3. A perpetrator's violent history should be the starting point for all assessments of risk and proportionate enquiries always need to be made. In complex situations, practitioners need to have confidence to arrange a multi-agency professional's meeting to manage the risk that an individual may pose to others, whether this be by statutory or informal processes.

3.5.4. Despite their inability to engage Julie at the time, Sussex Police should be commended for having pursued an 'evidence-based' prosecution in the absence of a witness statement on the second report. However, there were several occasions when no further action was taken against the perpetrator, for a variety of reasons, and the review considered that the perpetrator may not have felt accountable for his violence and abuse.

3.5.5. Aside from the MARAC, there were a number of opportunities to bring practitioners together to manage the threat that the perpetrator posed. This was particularly evident when the perpetrator was disengaging with probation and mental health services from early 2018 onwards. Moreover, his case should have been escalated to the National Probation Service by the Community Rehabilitation Company at various points because of the high risk of serious harm that he posed.

3.5.6. Critically, the perpetrator's licence conditions were not robustly managed by probation services and a Serious Further Incident Review has found significant failings in the probation response. Moreover, a Section 117 (Care Act 2014) was not completed by

the local authority or mental health services when he was being released from hospital. Section 117 places an enforceable duty on health and adult social care services to offer care to meet mental health needs thereafter. Had it been applied, the perpetrator could have to be subject to regular reviews, enabling aftercare services after his discharge from hospital to prevent any relapse in his mental illness. However, it was noted that the perpetrator would have been under no obligation to accept the after-care services had they been offered, without any other legislation or orders being applied.

3.6. Identifying carer's risks and needs

3.6.0. The perpetrator has a severe and enduring mental health condition which relies upon his compliance with medication and Julie often alerted services when her partner's mental health was deteriorating. Indeed, she had done this on the day of her death, although this was the first time that she had direct contact with secondary mental health services. However, Julie was not recognised as carer and not offered a carer's assessment where an opportunity to discuss her own needs and caring responsibilities could have taken place.

3.6.1. Practitioners have safeguarding responsibilities towards the family members and carers of service users. In order to understand the risks that they may face, practitioners need to encourage dialogue and engage with family members, wherever possible. They also need to be offering a carer's assessment if they become aware that a household member is providing significant caring responsibilities to someone with severe and enduring mental health problems

3.6.2. Co-existence of severe mental illness and substance misuse

3.6.3. Substance misuse was found to be a recurring issue in the perpetrator's offending and deterioration in his mental health, yet he was not known to substance misuse services. This was despite substance misuse being part of his licence conditions at one point, when the conditions were not enforced by probation. The potential for dual diagnosis did not appear to have been considered by criminal justice agencies who were best

placed to recognise it in relation to his offending. The review considered the evidence which indicates that individuals with a dual diagnosis are most likely to disengage from services and have poor outcomes from mental health services. The need for all agencies to be alert to dual diagnosis and enable the dual diagnosis pathways to be followed was therefore recognised as particularly important.

4. Recommendations

4.1 Overview Recommendations

Recommendation 1: Routine Enquiry

East Sussex Community Safety Partnership should seek assurance that all health services in their area have implemented policies, pathways and staff training to support routine enquiry in domestic abuse.

Recommendation 2: Identification of clinical staff

Health agencies in East Sussex should ensure that all clinicians are readily identifiable in case notes and in the decisions they have made.

Recommendation 3: Domestic Violence Disclosure Scheme

East Sussex Community Safety Partnership should raise awareness amongst partner agencies of the benefits and opportunities of the Domestic Violence Disclosure Scheme and the process of applying for safe disclosure to victims of their abuser's history of violence and abuse

Recommendation 4: MARAC

MARAC Steering Group

- all MARAC partners to send a representative from the relevant service/team to take part in the MARAC where there is significant involvement (current or historic) that impacts on current risk management and safety planning

- to take pro-active steps to take further actions or alternative actions to address the risk/issue identified at MARAC, including all realistic means of managing the offender
- to consider how MARAC action plans and case management can be overseen and by whom
- An information sharing mechanism to be developed between GP Practices and the MARAC

The MARAC Support Team

- to consider how to identify the relevant social housing provider so that they are invited to MARAC for cases where their tenants are featured
- to ensure that records of MARAC meetings accurately reflect the sources of information received

Recommendation 5: Managing Perpetrators of Domestic Abuse. East Sussex Safer Communities Partnership should seek assurance from agencies that they are capable of harnessing multi-agency action to effectively manage and constrain perpetrators of domestic abuse.

Recommendation 6: Identification of Risk to Family Members and Carers. East Sussex Health and Wellbeing Board seeks assurance from its agencies that they are delivering their responsibilities to carers under the Care Act 2014.

Recommendation 7:

That the report is shared with the Ministry of Justice in order that:

- the implications of shortages of probation officers on professional standards are noted

- consideration is given, within the restructure of the probation services, to the professional registration of probation officers to ensure that individual standards of professional practice can be regulated
- consideration is given to providing a list of internationally commensurate probation qualifications

4.2 Individual Agency Recommendations

Change Grow Live Domestic Abuse Portal

- Where there is a discrepancy to a risk assessment based on a further assessment or professional judgement, it is first discussed with the referring agency, before implementing service processes relevant to that risk level.
- Creative engagement should still be a consideration, whilst following safe practices. Joint visits especially in services where the victim already attends is considered good practice, e.g. GP or Probation. If engagement is not possible the Portal will offer consultation to other professionals where the victim is likely to attend. This must also be balanced and in accordance with GDPR.
- Services to bring creative suggestions to MARAC, ensure that DVPO/DVDs and community and statutory services are considered for victim and offender.

East Sussex County Council Adult Social Care

- Ensure affected staff are accessing both IT systems as agreed
- Ensure all communication/ risks discussions at MARAC are appropriately updated onto both ESCC & SPFT IT systems ASAP but no longer that 24 hours following MARAC discussion.

East Sussex Healthcare NHS Trust

- Develop a health pathway and embed into routine enquiry & NICE standards in A&E.
- Demonstrate that efforts to improve staff awareness and responses to domestic abuse in recent times are proving successful.
- As well as training to identify signs and indicators of domestic abuse, training, procedures and pathways need to be embedded about how practitioners/clinicians respond effectively to domestic abuse.

Sussex Clinical Commissioning Groups

- That codes on the case recording system are used to flag people at risk of domestic abuse. This will aid GPs and nurses in the identification of people at risk and prompt accessing historical records to allow previous concerns to be address on subsequent consultations
- That GPs and nurses refer to historical records during consultations to enable any outstanding health issues to be identified and discussed
- Following significant events at the surgery, where risk to individuals has been identified, that a review is undertaken to ensure all relevant information is shared around identified risks.
- That the practice implements a domestic abuse policy outlining the roles and responsibilities of staff, as well as resources to support people using and working for the practice.

Kent Surrey and Sussex Community Rehabilitation Company

- KSS CRC to meet the expected standards for pre-release contact.
- KSS CRC Senior Probation Officers to demonstrate professional curiosity and effective management oversight.
- KSS CRC to ensure that the competencies of temporary and/or agency staff are checked.

Sussex Community NHS Foundation Trust

- Uckfield SCFT Minor Injuries Unit to raise awareness of the signs of domestic abuse and the appropriate pathways to seek support for the victim
- Wider East Sussex SCFT Minor Injuries Units (Lewes and Crowborough) to raise awareness of the signs of domestic abuse and the appropriate pathways to seek support for the victim
- Wider SCFT Minor Injuries and Urgent Treatment Centres:
- To raise awareness of the signs of domestic abuse and the appropriate pathways to seek support for the victim
- Raise internal awareness of SCFT IMR findings

Sussex Partnership NHS Foundation Trust

- Lack of known and understood legal restriction gave the perpetrator the choice to disengage with services and decline depot medication. His Care Plan and engagement was reliant on the perpetrator making contact and attending appointments when he was clear that he did not believe that this was necessary, there was no contingency for disengagement despite a history of disengaging and becoming unwell.
- Positive plans for engagement to be clearly documented with any restrictions or alerts to be discussed with Multi-Disciplinary Team.
- Ensure that patients that have been de-registered from a GP are supported to re-register and that prescriptions are delivered to a community pharmacy so assurance can be sought re collection.
- Where engagement is an issue, consideration of use of mental health act should be discussed and documented with a rationale for decision making.
- HCR20 risk assessment to be completed for all forensic inpatients

- Protocol to be put in place to ensure that all eligible patients receive a Section 117 discharge meeting.
- Triangle of care to be fully implemented with all patients
- Protocol to be developed to ensure that information shared by MARAC is accessible, checked by all Lead Practitioners and incorporated into risk management plans.

Sussex Police

- The Head of Public Protection should ensure that a review of DASH risk assessment is incorporated within the ongoing force DA Improvement Plan to ensure that the level of risk is being appropriately identified / graded by officers and staff. This review should be undertaken as soon as practicable.

Appendix A: Review Panel Members

Name	Role/Organisation
Paula Harding	Independent Chair
Alison Cooke	Named Nurse Adult Safeguarding, Sussex Community NHS Foundation Trust
Bryan Lynch	Deputy Director of Social Work, Sussex Partnership NHS Foundation Trust
Debbie King	The Portal (multi-agency domestic and sexual abuse service), Change Grow Live
Domenica Basini	Assistant Director for Safeguarding and Quality, NHS England
Gillian Field	Designated Nurse Safeguarding Adults, Sussex Clinical Commissioning Groups
Julie Wooderson	Detective Sergeant, Safeguarding Reviews, Strategic Safeguarding Team, Sussex Police
Lee Whitmore	Assistant Chief Probation Officer, Kent Surrey and Sussex Community Rehabilitation Company
Rosalind Green	East Sussex Adult Social Care, Professional Lead for Social Work
Lindsay Adams	Strategic Commissioner for Domestic Abuse and Sexual Violence, East Sussex County Council
Micky Richards	Director, East Sussex Change Grow Live
Natasha Gamble	Partnership Officer for Domestic, Sexual Abuse and Violence, Joint Domestic, Sexual Violence & Abuse and Violence Against Women & Girls (VAWG) Unit, Brighton & Hove and East Sussex County Council
Paul Cotton	Southern Housing Group

Appendix B: Key Lines of Enquiry

The review sought to address both the 'circumstances of particular concern' set out in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) and the following specific issues identified in this particular case:

- To analyse key episodes in agencies' response including the nature of assessments, decision making and responses and whether they met the expected standards of practice and procedures.
- To consider how agencies held the perpetrator accountable for his domestic abuse and violence to others and manage the risk that he presented?
- To consider how agencies' understanding of the perpetrator's mental illness impact upon their response to his domestic abuse or violence to others?
- To consider how barriers to engagement with the victim and perpetrator overcome?
- To consider, if domestic abuse was not known, how agencies identified the existence of domestic abuse from other issues presented? For example, were there policies and procedures for direct, routine or clinical questioning on domestic abuse and how were they followed in this case?
- To consider how robust was multi-agency working. To assess how effectively agencies worked together to assess, make decisions and respond to the risks, threats or needs identified. How did agencies share information concerning the perpetrator's risk to others? How did agencies access or work with specialist domestic abuse agencies? How robust and timely were Multi-Agency Risk Assessment Conference (MARAC) referrals and interventions and how were agencies made accountable for their actions?
- How well equipped were practitioners in responding to domestic abuse? How were staff supported to respond to issues of domestic abuse through policies, procedures, training, supervision, management and sufficient resources available at the time.
- To outline each agency process and practice in generating or responding to a Single Agency Combined Assessment of Risk (SCARF).

Questions posed by the bereaved family

- The perpetrator had a history of smothering and strangulation. How did this history feature in later risk assessments?
- Was the perpetrator let out of prison with enough supervision?
- Did the victim know about the perpetrator's violent past?
- Were there any indicators that the victim was vulnerable to grooming?
- On the day before she died, the victim had contacted the mental health service about him not taking his medication whilst taking other drugs. How did they respond?

In addition to addressing the key lines of enquiry, specific agencies were also asked to respond to the following additional questions within their IMRs:

- Adult Social Care (East Sussex County Council) to also
  - Consider what expectations there would be for an AMHP to access background information before a Mental Health Act assessment and why the AMHP did not have access to information concerning the MARAC or bail conditions for the perpetrator in this case.
  - Consider their engagement with the victim and whether opportunities to routinely enquire about domestic abuse could have been available

- Kent, Surrey and Sussex Community Rehabilitation Company to also
  - Outline the powers and responsibilities of managing an offender on licence, powers of recall and within post sentence supervision and how these were applied in this case
  - Outline the thresholds for approved premises; consider whether the perpetrator's circumstances met those thresholds and, if not, whether consideration or arrangements were made to secure alternative accommodation for him away from the victim
  - Identify opportunities for interventions with the perpetrator over his violence
  - Consider whether the perpetrator could have been managed under the Integrated Offender Management Framework and what additional interventions would have been potentially available to manage his behaviour under this scheme

- Sussex Partnership NHS Foundation Trust to also
  - Identify how the perpetrator's diagnosis of paranoid schizophrenia in 2009 was addressed in subsequent assessments and treatment
  - Outline how the perpetrator's compliance with medication was monitored and encouraged
  - How the service engaged with the victim as a carer and/or a person at risk
  - How the service responded to the perpetrator's complaint(s) that his partner (the victim) was not supportive
  - Nature of communication between the primary care team and the forensic psychiatric team
  - Assess the effectiveness of the prescribing method in final months before the death
  - Whether the Sussex Partnership regularly attended MARAC at this time and improvements since

- GPs to also

- Review the effectiveness of the 'special patient scheme' in enabling access to primary care services for the perpetrator
- Whether there were opportunities to share information with other agencies regarding the perpetrator's violent behaviour or concerns that he did not feel safe at home (disclosed in October 2017)
- Identify whether the victim was seen to have any caring responsibilities for the perpetrator, including assisting with compliance with medication, and if so, how she was responded to within this role
- Consider the nature of communication between the primary care team and the forensic psychiatric team
- Outline their domestic abuse procedures

- East Sussex Healthcare NHS Trust
  - to outline their domestic abuse practice and procedure and identify barriers to active engagement when the victim disclosed domestic abuse
  - to detail whether an Independent Domestic Violence Advisor was working within the Emergency Department at the time of the victim's disclosure of domestic abuse and since.

- National Probation Service to also
  - Identify opportunities for interventions with the perpetrator over his violence
  - Comment on the absence of a pre-sentence-report prior to the perpetrator's sentencing

- Southern Housing Group
  - To outline processes and arrangements for identifying and responding to vulnerable tenants
  - How the family's mental health issues, which were identified at the start of the tenancy, were responded to in order to ensure that the tenancy was sustained.
  - Whether there were any indicators of domestic abuse throughout the tenancy, such as rent arrears, anti-social behaviour or repairs that may be domestic abuse indicative, and how these were responded to
  - Whether the Housing Group has domestic abuse policies and procedures and whether these were adhered to

Briefer and summary reports were requested from:

- CGL Domestic Abuse Portal to provide
  - a summary of the support that they provided to the victim regarding domestic violence that she experienced from others in 2012

  - to identify how engagement was sought with the victim in April 2016 and October 2017 and whether these attempts met expected standards of practice in engaging with 'hard to engage' victims.
  - To detail its response to DASH scoring in October 2017

- Crown Prosecution Service to advise on their decision making around charges brought against the perpetrator
- HM Prison Lewes regarding the perpetrator's periods in prison
- Hyde Housing in respect of their involvement with the victim and perpetrator during their ownership of the social tenancy prior to it being transferred to Southern Housing Group in April 2018.
- Joint Domestic and Sexual Violence and Abuse and Violence Against Women Unit was asked
  - To provide an outline of MARAC processes and agencies participating in the area at the time.
  - To identify referrals to MARAC in this case; the nature of abuse and history identified; the agencies involved; the actions recommended and how actions were progressed.
  - To identify whether there have been any changes in the process and procedure of MARAC since which could have impacted upon this case?
- Sussex Police to provide
  - a summary of the perpetrator's contact with the police prior to March 2016 and outcomes of any criminal proceedings taken
  - a summary of the victim's contact with the police prior to March 2016 in respect of domestic violence and abuse from any perpetrator

Appendix C: Agency Involvement in the Review

Individual management reviews and chronologies were requested from the following organisations:

Chronologies and Individual Management Review (IMRs) were requested from the following organisations:

- Clinical Commissioning Group (in respect of primary care services)
- Change Grown Live (CGL) Domestic Abuse Portal
- East Sussex Healthcare NHS Trust
- East Sussex County Council Adult Social Care Services
- East Sussex County Council Safer Communities Team
- Kent and Sussex Community Rehabilitation Company (to incorporate National Probation Service response)
- Sussex Community NHS Foundation Trust
- Sussex Partnership NHS Foundation Trust
- Sussex Police
- Southern Housing Group

The following agencies had less involvement and were asked to provide briefer reports and chronologies:

- CGL Domestic Abuse Portal
- Crown Prosecution Service
- HM Prison Lewes
- Hyde Housing
- Joint Domestic and Sexual Violence and Abuse and Violence Against Women Unit
- National Probation Service
- Wealden District Council

The following agencies were contacted but confirmed that the victim or perpetrator were not known to them or that their involvement was not relevant to this review:

- Eastbourne Borough Council
- East Sussex County Council Children's Services
- Hastings District Council Housing Services
- Home Works (housing support service in East Sussex)
- Lewes District Council Housing Services
- Maidstone and Tunbridge Wells NHS Trust
- Optivo (social housing provider)

- Refuge (domestic abuse services)
- Sussex MAPPA
- STAR (substance misuse services in East Sussex)
- SWIFT Specialist Family Service
- Victim Support