

Domestic Homicide Review

Executive Summary

B/2012

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Commissioned by:
Kent Community Safety Partnership
Medway Community Safety Partnership

1 Introduction

1.1 Background to the Review

- 1.1.1 This summary outlines the process undertaken by the Kent and Medway domestic homicide review panel in reviewing the killing of B by her estranged husband S on the 30th April 2012.
- 1.1.2 Criminal proceedings have been completed and on 11th January 2013 S was found guilty of B's murder. He was sentenced on 14th January 2013 to life imprisonment with a recommendation that he serves a minimum of 28 years.
- 1.1.3 The purpose of the review was to:
- establish what lessons are to be learned from B's death regarding the way in which local professionals and organisations work individually and together to safeguard victims of domestic abuse;
 - identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
 - apply these lessons to service responses including changes to policies and procedures as appropriate; and
 - prevent domestic abuse homicide and improve service responses for all domestic abuse victims and their children through improved intra- and inter-agency working

1.2 Review Process

- 1.2.1 The process began with an initial meeting on 4th July 2012 of all agencies that potentially had contact with B and S prior to B's death.
- 1.2.2 Agencies across Kent and Medway, including specialist domestic abuse agencies, were contacted and asked if they had any knowledge of B and S.
- 1.2.3 Agencies were asked to give chronological accounts of their contact with both B and S from 1st July 2003 (the date when S joined Kent Police and the couple were believed to have met) until B's death on 30th April 2012 and to include any relevant information prior to July 2003. Where there was no involvement or insignificant involvement agencies advised accordingly. Each agency's report covers the following:
- a chronology of interaction with B and S;
 - what was done or agreed;
 - whether internal procedures were followed; and
 - conclusions and recommendations from the agency's point of view.
- 1.2.4 The following agencies submitted individual management reports of their involvement with B and S:
- Kent Police
 - Kent and Medway NHS and Social Care Partnership (KMPT)

- 1.2.5 Additionally, chronologies or briefing reports were received from four agencies that had limited contact with the couple during the relevant period and had information that would assist the review:
- GP
 - East Kent Hospitals University Foundation Trust (EKHUFT)
 - KCA
 - Private recovery clinic
- 1.2.6 Kent Police included S's record as a serving officer with the force from July 2003 to January 2010.
- 1.2.7 The police report shows that B contacted Kent Police on five occasions between December 2009 and March 2012 to report domestic abuse/concerns about S.
- 1.2.8 The incidents reported by B included a verbal altercation between the couple with minor damage to their home in December 2009; harassment from S, including a threat to kill in October 2011 after the couple had separated (B also disclosed past violence at this point); threats in February 2012 from S to visit B at her father's home after the couple had separated again; concern that S was threatening to kill himself in February 2012; threatening behaviour from S outside B's father's house in March 2012. B was reluctant for any police action to be taken against S. Following the report made in October 2011, S was visited by a police officer but not arrested. He was subsequently visited by a firearms officer in November 2011 and agreed to surrender his shotgun certificate and shotgun for 6 months. In February 2012 S was visited by a police officer because of B's concerns about his mental state and was taken to a psychiatric unit for a mental health assessment.
- 1.2.9 The GP, KCA and EKHUFT had no knowledge of domestic abuse in the couple's relationship. Mental health practitioners were not alert to an indicator of domestic abuse when undertaking an assessment of S's mental health in February 2012. A counsellor at the private clinic was aware that S had strangled B so that she lost consciousness in March 2012, but she accepted B's assurance that she had notified the police of the incident, which was not the case.

1.3 Family input to the Review

- 1.3.1 Relatives of B were notified of the review by their police family liaison officer and offered the opportunity to meet with the overview report writer after the conclusion of the criminal trial. B's father duly met with the author and gave a helpful perspective of the tragic events. Her mother chose not to meet with the author.
- 1.3.2 B's father was aware that there were gaps in communication in the police handling of the incident at his house in March 2012. However, he took the view that no agency could be held responsible for B's death and that responsibility rested solely with S. He did, though, think that the police officers who visited

his home in March 2012 should have interviewed him and B's friend, V, as they had relevant information about S's behaviour.

- 1.3.3 B's father believed that she did not wish to support a prosecution of S because she wanted to avoid him acquiring a criminal record, fearing that this would impede his future career ambitions. B wished S to be successful, in the hope that it would enable him to move on from their marriage and leave her alone. B's father did not believe that S's former employment as a police officer had any bearing on B's reluctance to disclose to the police the full extent of the domestic abuse she had suffered. He confirmed that he was not aware of all the abuse; B was a very private person and revealed very little to family members and friends.
- 1.3.4 B's father, brother and sister in law met with the author after they had read the overview report. They were content with its conclusions. They expressed their concern that the police investigation in March 2012 was insufficiently thorough, as the investigating officers were not aware of all the circumstances (notably the information on the Computer Assisted Dispatch) and did not interview B's father or her friend, V. B's family hope that lessons will be learned from this missed opportunity, especially the importance of interviewing family members/friends, as they might have information which a victim of domestic abuse is reluctant to disclose.

1.4 The Review Panel

The review panel membership was as follows:

- Helen Davies, Independent Chair and Overview Report Writer (an independent consultant)
- Andrew Coombe/Rosetta Lancaster, NHS Kent and Medway
- Tim England, Medway Community Safety
- Alison Gilmour, Kent and Medway Domestic Violence Co-ordinator
- Carol McKeough/Yvonne Phillips, Kent Families and Social Care
- Shafick Peerbux, Kent Community Safety
- Tim Smith/Andy Pritchard, Kent Police

It met on four occasions between 4th July 2012 and 17th April 2013.

2 Key issues arising from the review

- 2.1 There were a number of missed opportunities to take more assertive action to protect B from S. In October 2011, Kent Police could have arrested S for sending malicious communications to B or he could have been issued with a harassment warning. In February 2012, Kent Police did not act on B's report (in the context of her concerns that S might harm himself) that S had been carrying a knife when he went to her address the previous day. This should have resulted in further investigation into an offence of possession of an offensive weapon.

- 2.2 By March 2012, there was evidence of a number of risk factors in S's circumstances and behaviour. He took cocaine and drank heavily but there is no evidence that he was dependent on these substances. He described himself as depressed and stressed. It appears that he did not accept that the marriage was over after B left him in February 2012. He was abusive, threatening and controlling towards B. He was extremely jealous and, after their separation in February 2012, harassed B through persistent texts, phone calls and visits. It was also known that he had made threats to kill B, that he had been to B's father's address (where she was living) carrying a knife in February and it was alleged by a male friend, V, that in March S had strangled B until she lost consciousness.
- 2.3 Unfortunately, all of this information was not collated, as the alleged strangulation was not known to the police officer who investigated the incident at B's father's address on 13th March 2012, and B did not disclose it when interviewed. Nor was the Computer Assisted Dispatch (CAD) completed by the force control centre, which contained this information, entered on the crime report and examined alongside the report of the incident at B's father's home by the supervisor at the multi-agency Central Referral Unit (CRU). Had all the information been collated, the DASH (Domestic Abuse Stalking and Harassment) risk assessment in March 2012 should have been graded 'high' risk and a multi-agency risk assessment conference (MARAC) should have been convened to assess all the risks and devise a multi agency safety plan for B. Also, the alleged strangulation should have been investigated by Kent Police.
- 2.4 Police investigations following B's murder revealed that a counsellor at the private recovery clinic knew of the strangulation, as it was discussed between B and S in a conjoint meeting at the clinic in March 2012. However, she accepted B's assurance that B had notified the police of the assault, so understandably did not report it to the police, but this was another lost opportunity as S acknowledged the assault.
- 2.5 Police investigations also revealed that several friends and family members had information about the escalating domestic abuse B suffered over many years, but no one had the full picture.
- 2.6 This case confirms research evidence (*Wilson, M, and Daly, M (1993). Spousal homicide, risk and estrangement. Violence and Victims, 8,3-16 and Campbell, J (1995). Prediction of homicide of and by battered women in JC Campbell (ed), Assessing Dangerousness; Violence by the sexual offenders, batterers and child abusers, London: Sage*) that the most dangerous time for a female victim of domestic abuse is when she ends the relationship. Once S realised that their marriage was over, he exerted his control over B for a final time by killing her.
- 2.7 The quality of DASH assessments completed by frontline police officers was variable, so it is important their training is regularly refreshed and that supervisors scrutinising them have the capacity to collate all relevant background information to inform their decisions about level of risk.

- 2.8 When victims of domestic abuse are reluctant to engage with the police and support a prosecution, police officers should, nevertheless, investigate incidents fully and consider the full range of options at their disposal, both criminal and civil to try to prevent further abuse.
- 2.9 Some elements of a safety plan were put in place for B after the DASH risk assessments in October 2011 and March 2012, but they could have been more comprehensive. It might have been beneficial if police officers could have persuaded her to involve family, friends and colleagues in them.
- 2.10 There are particular sensitivities when a perpetrator of domestic abuse is a serving or former police officer. There is variable knowledge among police officers about the required actions to be taken within the force in respect of a serving officer. Also, there may be difficulties for victims in engaging with the police, so options such as the involvement of independent domestic violence advisers should be considered to facilitate their engagement.
- 2.11 Mental health practitioners were not alert to an indicator of possible domestic abuse when assessing S under section 136 of the Mental Health Act, and did not enquire in depth about the potential for domestic abuse when assessing the risk to others.

3 Conclusions

- 3.1 This review has identified ways in which practice could be improved within Kent Police, Kent and Medway NHS and Social Care Partnership Trust (KMPT). It has focussed on domestic abuse, so has not addressed in depth Kent Police's management of the perpetrator's difficulties in the last two years of his service. There is no evidence that anyone in Kent Police had information that S was involved in domestic abuse until the day of his resignation. However, Kent Police in its own independent management report has made a recommendation about reviewing its policy for self disclosed drug taking by police officers or staff.
- 3.2 There is no evidence that S's former employment as a police officer in Kent had any bearing on the handing of this case by Kent Police, nor that it deterred B from reporting abuse to them. It appears that her reason for not wishing to support prosecution was to avoid S acquiring a criminal record. B wished him to be successful in a new career, believing that this might enable him to move on and accept that their marriage was over.
- 3.3 There was evidence of escalating abuse towards B in the six months before her death and of risk factors in S's behaviour. The incidents in March 2012 should have been investigated more fully despite B's reluctance. They should also have resulted in a multi-agency risk assessment conference (MARAC) and a robust safety plan to reduce the risks to B.

- 3.4 However, it is not possible to conclude that the above actions would have prevented B's death. Nevertheless, they might have provided an opportunity for specialist domestic abuse services to work with B to devise a safety plan, which included her family and friends. Likewise, they could have resulted in services for S to address his abusive behaviour. Investigation of the alleged strangulation might have resulted in S being prosecuted and receiving a custodial sentence, thereby affording protection to B.
- 3.5 Although mental health practitioners did not follow up an indicator of possible domestic abuse when making their assessment of S, there is no reason to conclude that this had any impact on the tragic outcome, as the police were already aware that S was sending B abusive and threatening text messages.
- 3.6 The recommendations are designed to ensure that the lessons learned are addressed. They have been accepted by the agencies and their implementation will be monitored by the Kent Community Safety Partnership.

4 Recommendations

- 4.1 When police officers are dealing with reports of domestic abuse, all relevant information must be recorded on the crime or secondary incident report, which will assist in ensuring a proper risk assessment is made. In particular, relevant information from the Computer Assisted Dispatch (CAD) should also be included on the crime or secondary incident report.
- 4.2 When a person, other than the victim, makes an allegation of domestic abuse to the police, then officers must make contact, not only with the victim but also the individual making the allegation to develop the whole picture. Officers should be reminded of their responsibility to achieve a proper standard of investigation and to ensure that appropriate evidence is captured from key witnesses, paying particular attention to interviewing family and friends.
- 4.3 Police officers should be reminded that following a report of domestic abuse involving a member of Kent Police (either as a perpetrator or victim), that the Professional Standards Department should be informed, usually via a locally based supervisor of the rank of inspector or above.
- 4.4 Kent Police policy to be amended to direct that officers taking reports of domestic abuse perpetrated by a serving police officer/staff or retired police officer/staff should consider referring the victim to an independent domestic violence adviser (IDVA) or domestic abuse support worker.
- 4.5 When an alleged perpetrator of domestic abuse is also the holder of a shotgun or firearms certificate, Kent Police should ensure that a risk assessment in relation to the possession of firearms by suspected perpetrators takes place, and in such cases consideration should be given to removal of any firearms as a matter of urgency.

- 4.6 The planned review by Kent Police of the central referral unit (CRU) should consider the capacity of the unit to carry out effective assessments of crime and secondary incident reports graded as 'standard' risk. The review should also consider whether the assessment of such cases should be the responsibility of divisional supervisors rather than the CRU.
- 4.7 When a person is detained under section 136 of the Mental Health Act resulting from circumstances which may directly or indirectly relate to domestic abuse, Kent Police should record the details on a secondary incident form.
- 4.8 When KMPT staff receive information that could indicate a patient is a possible perpetrator of domestic abuse, they should seek further specialist advice about the most appropriate action to take. Evidence of this consultation and decision making must be recorded.
- 4.9 When KMPT frontline practitioners identify that a client may be a perpetrator of domestic abuse, they will ensure that this is clearly identified on the KMPT risk assessment. Concerns will be discussed within supervision and multi-disciplinary team meetings.
- 4.10 Following detention and assessment under section 136 of the Mental Health Act, when any indication of domestic abuse is identified by completing KMPT's risk assessment process, a detailed letter should be sent to the client's GP advising follow up.
- 4.11 Domestic abuse training to be provided for GP surgeries, including competencies for all staff. Once the core competencies have been identified, training will be rolled out to all surgery and primary health care staff.
- 4.12 Domestic abuse training to be delivered to all Clinical Commissioning Group (CCG) Board members, including required assurances, governance arrangements and domestic homicide review responsibilities.
- 4.13 CCGs to expedite the appointment of a named GP for adult safeguarding; the postholder would complete individual management reports for domestic homicide reviews.

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