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DOMESTIC HOMICIDE
OVERVIEW REPORT

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Chief Executive
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1. INTRODUCTION

1.1 This report of a Domestic Homicide Review examines agency responses and support given to Fiona Johnson, a resident of Essex prior to the point of her death on 6th June 2011.

1.2 Fiona Johnson and her daughter Olivia were shot dead by George Randall, Fiona's ex-partner and Olivia's father on 6th June 2011 in their home in Downton[1]. George used a shotgun which had been illegally obtained.

1.3 The review will consider agencies involvement with Fiona Johnson and George Randall from April 2009 until June 2011. The key purpose for undertaking Domestic Homicide Reviews is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

Terms of Reference

1.4 Terms of Reference were drawn up and are included as appendix one of this report.

Methodology

1.5 A Domestic Homicide Review (DHR) Panel was created made up of a small number of managers who have knowledge of the Downton area and expertise in aspects of work with children, families and Domestic Abuse at some level. The overview chair came from Downton Community Safety Partnership and is the Chief Executive of Downton District Council.

[1] Downton is a fictitious area of Essex

1.6 The Panel consisted of:

- Chief Executive, Downton District Council
- A Senior Manager from Essex Probation
- A Superintendent from Essex Police
- The Designated Nurse Safeguarding Children NHS Essex
- A Community Services Manager Downton District Council
- An Assistant Director of Public Health for NHS Essex
- An independent member of the Panel who is a member of the Essex Safeguarding Adults Board management committee and chair of the area Essex Safeguarding Adult Board.
- An operational Service Manager from Adult Social Care Essex County Council
- A Quality Assurance Manager, Essex Children's Services

A representative from a voluntary organisation offering support to victims of Domestic Abuse was invited but was unable to attend any meetings due to personal reasons.

1.7 An Independent Chair and Overview Author was appointed by the CSP. They are a qualified social worker and has worked as a team manager, and also ran a women's refuge. They became a Director of an Advocacy Company in 2007. They have a Master's degree in management, and is also a member of the Safeguarding Adults Management Committee and Essex Adults Safeguarding Board.

1.8 The Panel Chair is an experienced manager and report writer but in November 2012, they stepped down from being the Panel Chair and overview author. The Chair role was taken over by the Downton Community Safety Partnership Chair, and overview author role was taken over by Barry Raynes who had just completed the overview report for the serious case review held in Essex in relation to the death of Olivia Johnson.

1.9 Barry is the chief executive of Reconstruct, a company providing training and consultancy to Social Care managers and staff throughout the United Kingdom.

1.10 Barry has thirty years' experience of social work. He has been involved in over 30 serious case reviews since 2007 – either overseeing the work of Reconstruct's consultants or producing overview reports.

1.11 Barry has a Master's degree in Public Sector Management and is currently researching a PhD into common language in interagency Social Care practice.

1.12 All relevant agencies were asked to produce a chronology and an individual management review (IMR) of their contact with members of the family.

The chronologies were combined to create a joint chronology and this is included as appendix two to this report.

1.13 The individual management reviews were assessed by the Panel and were considered to be of at least an adequate standard for the purposes of this review.

Parallel Processes

1.14 This report is being written at the same time as a serious case review and just after the publication of an IPCC[2] report. This report has therefore drawn upon the IMRs produced for this review and the IPCC report as well as the knowledge obtained from the Serious Case Review.

1.15 Although providing further evidence for the report the three reviews have made the process complex to manage and co-ordinate.

1.16 The IPCC report was used because it contains information that was not made available to the Police IMR authors for both this review and the serious case review. In particular this is the information provided by neighbours and adult members of the family. We were unable to interview Police Officers and other witnesses directly because they were involved with the criminal prosecution and the IPCC enquiry.

1.17 With the serious case review and the Domestic Homicide Review being held at a similar timeframe, both Panels had a nominated representative who sat on the opposite Panel. This provided a more rounded approach to the two reviews and ensured that key elements were explored and analysed by the most appropriate Panel. This ensured consistency across the respective reviews from both the adult and child perspectives, and also ensured that any differences in agency IMRs could be questioned.

Timescale and timeframe for the review

1.18 This review began in September 2011 and was concluded on 26th April 2013. Reviews, including the overview report, should be completed, where possible, within six months of the commencement of the review.

1.19 This review process in its entirety has taken twenty months to complete. This delay has been caused by a number of factors:

- Agencies lack of familiarity with the process
- The change in Chair and Authorship of this report
- The requirement for the Home office to quality assure all domestic homicide reports before they are published
- The criminal prosecution of George Randall

[2] Independent police complaints commission

1.20 The time frame chosen for the review was from the birth of Olivia to her, and her mother's deaths. This fitted with the timeframe for the serious case review.

Family and community involvement

1.21 Fiona's parents and sister Carol, were informed about this review at the beginning of the process. Approaches were not made to meet with them until the conclusion of George Randall's trial as contact may have contaminated the Police prosecution of George Randall.

1.22 In June 2012, following the conclusion of the trial, approaches were made to the family for the authors of this report, and the author of the serious case review overview report to meet with the family together. However no response was received from the family at that time. They met with the author of the IPCC report and their views were included in that report.

1.23 In September 2012 Barry Raynes visited Fiona's children and their views were included in the serious case review and are included in this report.

1.24 In January 2013 Barry met with the children's maternal grandparents (Alice and Arthur Johnson) and their aunt (Carol Johnson). He met with Carol again in March and April 2013 to go through this report in detail with her. Their views are included throughout this report.

1.25 These meetings were facilitated by a victim support homicide case worker for the family.

1.26 Although this review has taken a considerable time to conclude, the delay did provide the family with time to decide that they wished to be involved. Their contributions have improved the learning from this review.

1.27 Barry attempted to meet with George Randall, offering to meet him in prison on two occasions but no reply was received. George died in prison in February 2013. Barry wrote to the father of other siblings on two occasions but never received a reply.

1.28 Barry will continue to liaise with the children, Fiona's sister and her parents until the conclusion of the reviews.

1.29 Both of Fiona's next door neighbours were written to but they declined to take part in this review.

1.30 The family have had a victim support Officer attached to them throughout the trial and these reviews. He has liaised with Barry in facilitating meetings with the family, passing on sensitive information and helping the family contribute to the reviews.

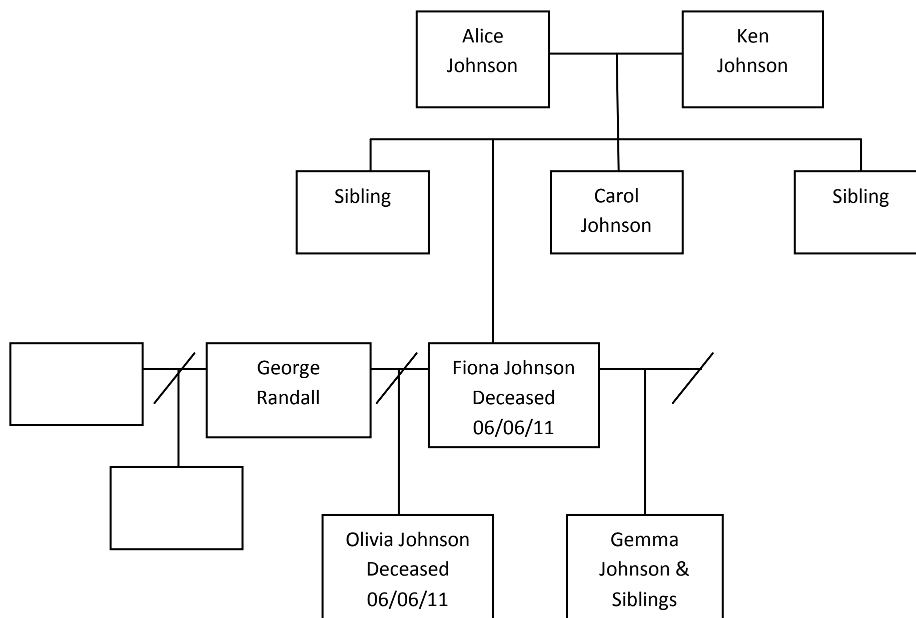
1.31 The involvement of the family has been facilitated hugely by the victim support domestic homicide Officer. Future DHR Panels should be mindful of the helpful role that these practitioners can play in assisting family involvement in the process.

Background to the review

1.32 Fiona Johnson was born in 1973, and had three siblings. Fiona had other children and lived with Gemma and Olivia in the same house for many years.

1.33 Fiona was in a relationship with George Randall, born in 1961 for about six years. They kept separate addresses but George spent a lot of time with Fiona, Gemma and Olivia. Olivia was George's daughter and he lived in a caravan.

Family tree



Race, religion, language and culture

1.34 George, Fiona, Gemma and Olivia are of White UK origin. It is not known whether religion was an important part of their lives. Reports and IMRs did not address issues of culture and there has been limited contact between the family and this process, therefore it is regrettable, but not possible, for this report to address the issue in more detail.

1.35 Gemma and sibling told Barry, the author of this report, that there was a lot of violence in the family home perpetrated by George. They gave examples of violence that are not included in the records of professionals.

Dissemination of the report and learning

1.36 Once feedback has been received from the Home Office, the DHR & SCR will present a joint briefing to colleagues pan Essex on the tragic circumstances into the murders of Fiona and Olivia, the lessons learnt, and, the action plans. This will include specialist practitioners and service providers from community safety and safeguarding children and safeguarding adult arenas.

1.37 To date the DHR Panel members, the Essex Safeguarding Children Board Manager, Fiona's parents, sister and their Victim Support Liaison Officer have had sight of this report. Once published, a redacted copy will be made available to all.

Individual management reviews

1.38 Individual management reviews were received from

- Essex Police
- Children's Social Care
- Downton Council
- The Local Housing Association
- Essex NHS
- East of England Ambulance Trust
- Adult Social Care (No contact with family)

1.39 The quality of the individual management reviews were variable with those from agencies used to producing these reports for serious case reviews being of a higher quality than the reports produced from agencies who don't have this experience.

1.40 Nevertheless the overall quality was good enough to produce this overview report although reference was also made to the serious case overview report and the IPCC report.

1.41 The Panel decided to not ask for the poorer quality IMRs to be rewritten because there was enough information available from the parallel reviews to produce this report.

1.42 In addition Fiona's GP sent letters outlining their contact which was minimal.

1.43 The IMR Authors were invited to attend a Panel meeting to present their Review to the DHR Panel, and to take part in the collective discussion to raise and discuss points of clarification. The authors also provided information as to what has changed / been put in place as a direct result of their IMR.

Confidentiality

1.44 The findings of each review are confidential. Information is available only to participating Officers, professionals and their line managers.

2. CHRONOLOGY OF EVENTS

2.1 The information that follows comes from the joint chronologies produced for the serious case review and this report, IMRs which themselves drew upon case records and interviews with staff, the IPCC report and the author's conversations with family members.

2009

2.2 On 04/03/09 Fiona made a 999 call to Police reporting a Domestic Abuse incident at her home. She said that she had left the home because George Randall had threatened to kill her baby. She sounded very distressed and was worried as their baby Olivia was still with him.

2.3 Police Officers found George in the kitchen. The Police report described his behaviour as threatening and aggressive. He was standing by some knives so TASER Officers were deployed to the scene but were not used as:

> *"The situation was resolved by the Officers who distracted Randall whilst Mrs Johnson removed the child from the premises. Mrs Johnson and her two children left the house to spend the rest of the night with relatives,"* Police IMR, (paragraph 7.6).

2.4 Olivia and Fiona stayed at a relatives' house. Police believed that no offences had been committed so no further action was taken.

2.5 A DV1[3] was completed and sent to Children's Services and Health agencies. The DV1 system used by Essex Police to assess and grade Domestic Abuse situations is included as appendix three to this report.

[3] A DV1 is a form that police use to collect information when they have attended a scene of domestic violence. They are completed by police officers at the scene and are then passed to the police's own domestic abuse liaison officer for management oversight

2.6 At 2.25 a.m. on 06/04/09 Police received a 999 call from an anonymous female[4] stating that a man was trying to get into a caravan.

2.7 The line was left open and the following was recorded:
"Child shouting help mummy, male has taken Gemma, aged 7 in his vehicle, Male had a knife which he left behind, he has assaulted the infs partner" Police IMR, (paragraph 7.10).

2.8 Police Officers arrived at the scene. They later wrote that both Fiona and George had been drinking all day and were un-cooperative,
"Gemma Johnson was seen by Officers to be wearing a plaster, which was covering a cut, when queried by Officers, Fiona Johnson said the injury, a small cut, had been caused when Randall threw a can of beer at her, which missed Fiona and bounced up and accidentally struck Gemma," Police IMR, (paragraph 7.11).

2.9 Fiona refused to make a complaint and signed an Officer's notebook stating that she did not want any action to be taken. George was arrested for assault on Gemma.
"A DV/1 was completed…The incident was assessed as 'Moderate[5],"
Police IMR, (paragraph 7.14).

2.10 Details were sent to Children's Social Care and the health visitor.
"Ultimately, due to Fiona's refusal to supply a witness statement, or allow Gemma to be video interviewed and no additional corroborative evidence, the decision was made by a duty custody Inspector to 'refuse charge' Randall, as the evidence threshold had not been met to support a charge,"
Police IMR, (paragraph 7.14)

2.11 The DV1 was received by Children's Services on 07/04/09. The next day they recorded it under the heading "child protection" and they decided to undertake an initial assessment.

2.12 Four days later on 10/04/09 Police received a 999 call from a member of the public at a garage saying that a man (who was George Randall) had taken a little girl (Olivia) from a woman (Fiona) and the child was crying. The man,

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[4] The SCR police IMR says this person was male

[5] DV1s are graded as follows:

Standard Current evidence does not indicate likelihood of causing serious harm.
Medium (*moderate in 2009*) There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, and drug or alcohol misuse.
High There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious.

"was shouting and being abusive to the woman and stating that he was going to kill her if she did not give the child to him," Police IMR, (paragraph 7.15).

2.13 Apparently George then took Olivia back to his caravan. A Police Officer arrived and

"*encountered a volatile situation where further Police assistance was requested, resulting in George Randall being restrained and arrested for Breach of the Peace,"* (Police IMR paragraph 7.16).

2.14 He was later released without charge. Fiona told Officers

"she did not feel threatened by Randall…Fiona supplied a written statement..saying she did not want..him arrested,"

Police IMR (paragraph 7.18).

2.15 A further DV1 was completed assessing the risk as "moderate". According to the Police IMR author, this was not shared with health and Social Care because the children were omitted from the form. This may be incorrect though because, according to the health IMR author, the health visitor received notification of the incident on 16/04/09. There are no records that Social Care received notification. (This is further explored in paragraph 3.9).

2.16 On 15/04/09 a social worker attempted an unannounced visit to Fiona Johnson but no-one was in. The social worker was told by a neighbour that the family were on holiday. The social worker left a note asking Fiona to contact her. The social worker also contacted the Police child abuse investigation unit and was told that, as the Police Domestic Abuse unit was involved, the child abuse investigation unit wouldn't be.

2.17 On the same day the health visitor received the DV1 relating to the incident of 06/04/09. She noted that this incident had been assessed as a "moderate" risk of harm.

2.18 On the following day, 16/04/09 the health visitor received the DV1 relating to the incident of 10/04/09. She noted that this incident had been assessed as a "moderate" risk of harm and that George had been arrested.

2.19 On 21/04/09 the health visitor made a home visit and discussed the incidents with Fiona who told her that she had had a bad patch in her relationship with George but it was now sorted out. She described George as a "gentle giant" and admitted that she provoked him too. Fiona said she lied about the beer can now stating that it was a can of beans that had fallen out of a cupboard and hit Gemma when she had opened the cupboard door. Fiona said that George had never hit her. The health visitor recorded that a "loving relationship was observed" between mum and baby and that Fiona would contact her if she needed further support.

2.20 On 28/04/09 a social worker visited Fiona, spoke to her, saw the children and completed an initial assessment.

2.21 There are no further known Domestic Abuse incidents until late in 2010.

2010

2.22 There is little recorded information about the family for most of 2010 beyond what would normally be expected from school and GP, none of which is significant to this review.

2.23 Social Care "completed" the initial assessment

> *"on the 23rd January 2010 having been commenced on the 8th April 2009. The recommendation of the initial assessment was for there to be no further action and the reason stated for this was that 'Fiona has been monitored by the health visitor at a GP Surgery and will be supported. Fiona appears to be able to safeguard herself and the children from significant harm,"* Children's Social Care IMR, (paragraph 4.19).

2.24 On 07/11/10 an ambulance and Police Officers were called just after midnight to Fiona's address because a male there (now known to be George) had "cut his arm and stomach" and locked himself in. Fiona was next door with the children. Both George and Fiona were drunk. George was saying he would harm himself if Officers came into the house. Entry was forced at the rear of the house and George refused treatment from the paramedics. He was not arrested. No DV1 was completed and no further action took place on this matter. Police and ambulance services were the only agencies who ever knew that this incident had occurred.

2.25 Up to this point most of the contacts between the Police and this family had not been instigated by Fiona and George. From now on that balance shifts and both George and Fiona make more self-referrals.

2011

2.26 On 14/04/11 Fiona telephoned the Police to say that George had taken Olivia. She said that George did not have parental responsibility, apparently his name was not on the birth certificate. She said that he was using Olivia to "get what he wants out of her". She said she believed that he was at a caravan in Caravan Park 1.

2.27 Police Officers went to Fiona's house and spoke with her. She told them that her relationship with George had ended. They said that he had committed no offence because George was the father of Olivia and was not being reported as threatening. Police completed a DV1 but again Fiona:

"refused to answer....questions as 'she felt it was a waste of time, as there had been no violence when she had split up with Randall'," Police IMR, (paragraph 7.25)

2.28 The risk was assessed as "standard". Although a DV1 was completed this was not logged onto the system until after the deaths of Fiona and Olivia some seven weeks later.

2.29 On 17/04/11 Police received a phone call from a neighbour of Fiona's saying that Fiona was currently living with her mother because she was frightened of George and that Fiona had asked this neighbour to keep an eye on the house. George had now turned up and was removing possessions from the house. The Police telephoned Fiona and left a message asking her to ring them. She did so later and said she would return home the following day to see if anything was missing.

2.30 On 18/04/11 Police Officers visited Fiona at home on two occasions. The first was to find out whether anything had been taken. Fiona said that

"she is having disagreements over child custody issues, which are being dealt with by Solicitors. She did not want to make any complaints and Police took no further action," Police IMR, (paragraph 7.28).

2.31 The second occasion was caused by an unknown man phoning 999 to say that Fiona's home was on "high alert" and a male had just turned up.

"Officers were sent to the house, having been advised of the earlier visit by Officers. It is recorded on Storm that Officers spoke with occupants of the house ……. and that the unnamed occupant had no knowledge of Police being called. Attempts were made to phone back the number the call had come from, but got no response. It is not recorded on the incident who was seen at the house," Police IMR (paragraph 7.29).

2.32 The IPCC report states that a neighbour was present on one of these occasions and recalled to the IPCC report author that Fiona told the Police Officers that:

"Mr Randall had beaten her (Fiona) up lots of times," IPCC report, (paragraph 85),

though this does not appear to have been recorded by the Police.

2.33 On 21/04/11 Fiona applied for and was awarded a Non-Molestation Order from Court 1. In her application she detailed serious Domestic Abuse, none of which was known by any agencies at the time. The following are extracts taken from the application.

"I would estimate that he has used violence against me on around fifteen separate occasions... He then put his hands around my throat to strangle me, in the process breaking a necklace... He then punched me to the eye... As a result of this incident I had a black eye, which was visible for weeks after. I tried to disguise this with make-up and dark glasses... and ran up to me head-butting me... splitting the eyebrow where I have a piercing...he punched me in the side of the head hitting me on the temple. The blow was so hard I saw stars...I curled up into a ball as he began kicking me... I think I was kicked around six times whilst I was on the floor... grabbing me by the hair... so hard that some of my hair fell out... My hairdresser thought I had alopecia... On most occasions where there has been violence I have not reported matters to the Police... At that exact moment the children walked in and Gemma pleaded with him to stop. George then made a comment to another child that he didn't particularly like them. I then decided at that point that now the children had become caught up in the respondent father's aggression that I needed to get out of... I fear that now that I have ended this relationship I am in further danger of violence... I am very fearful that when he knows of my intentions he will respond angrily," Fiona Johnson' application for a Non-Molestation Order, (21/04/11).

None of this information was passed by the Court to any agency.

2.34 On 22/04/11 Fiona telephoned Police to say she had a Non-Molestation Order taken out the previous day on George. He had been calling her today saying that their daughter, who was still with him, had a stomach ache. She said that he had said "you really don't want to take this to Court". She had phoned the Police because he was harassing her.

2.35 Police Officers visited the house and checked the order as it wasn't listed on the Police national computer. Fiona asked the Officer whether texts constituted a breach of the Non-Molestation Order. The Police Officer advised her

"that should a complaint be made against her former partner, he would be arrested and held by Police until the next available Court date which is 26th April. This is also the date that she and her ex are going to the Children's Court to begin their custody battle. As such, any complaint made now would delay the civil case as the criminal proceedings would take precedence, therefore she declined to provide a statement about the text messages she has received since the Court order came into force," Police IMR (paragraph 7.30).

2.36 A DV1 was completed but not shared with partner agencies and it stated that the texts were neither threatening nor abusive, something that Fiona's family have confirmed to me saying that they were almost illiterate.

2.37 Later that day George telephoned the Police to say that he was going through a messy separation with Fiona and that she had phoned him and threatened to kill him. Police visited George and he told them that

> *"he had phoned Fiona to tell her of their daughters stomach ache, this had degenerated into an argument over the custody issues whereby she threatened to kill him,"* Police IMR, (paragraph 7.33).

2.38 A second DV1 (for that day, 22/04/11) was completed despite the fact that George refused to supply details for its completion. The incident was assessed as "medium". This DV1 was not shared with partners until after the deaths of Fiona and Olivia some 7 weeks later.

2.39 When interviewed Carol, Fiona's sister, told me that she was having regular contact with Fiona during this time. She described a phone call in which George asked Fiona if she wanted to speak to Olivia, Fiona then said "yes" but George didn't allow her to talk to Olivia, instead using the opportunity to tease Fiona.

2.40 On 26/04/11 there was a hearing in respect of Fiona's application for residence and specific issue orders. Olivia was returned to her mother's care.

2.41 Later that day George telephoned the Police to say that Fiona now had "full access" to Olivia and he feared for Olivia's safety. In response to this Police Officers visited Fiona's home and found it to be tidy, clean with food and toys and Fiona and Olivia in good health.

2.42 George then telephoned Children's Social Care.

> *"Mr Randall expressed concern for his child's welfare and made a number of serious allegations*[6] *in respect of Fiona. Mr Randall wanted someone to go to the home and assess the situation",* Children's Social Care IMR, (paragraph 4.21).

2.43 The recommendation was for no further action and the reasons given for this was that the:

> *"History suggests that father is the perpetrator of violence, not the mother as he alludes to and that is the reason a Non-Molestation Order has been granted. Father appeared angered with the current situation as he is not allowed contact with ex-partner or child,"* Children's Social Care IMR, (paragraph 4.23).

[6] These are not detailed in this report in respect to Fiona.

2.44 On 27/04/11 Fiona telephoned the Police to say that George was continually harassing her with phone calls and text messages. She said that she had waited until the Court case about Olivia was over but that she now wanted to make a complaint of harassment. A Police Officer visited and saw her and Olivia and took a statement of complaint. A DV1 was completed, although Fiona refused to answer the risk assessment questions; the risk was shown as "standard". This DV1 was not entered onto PROtect[7] until the 10th June 2011; therefore not shared with partner agencies until after the deaths of Fiona and Olivia.

> *"The Officer prepared the paperwork for Randall's arrest, but it appears he did not circulate him as wanted on the PNC[8],"* Police IMR, (paragraph 7.35).

2.45 On 28/04/11 George telephoned Police to say that he had seen Fiona near his caravan and he felt that she was trying to get him into trouble. He was given advice over the phone. He phoned back an hour later to say she was drunk and had recently been abusive to him. The Officer noted that this was probably malicious. Police Officers visited Fiona at her home later that day and found everything to be in order.

> *"An entry was added to the Storm[9] entry at 9.28pm stating: 'this could possibly be a malicious call as there is an ongoing custody/contact Court case at this time. Fiona Johnson was spoken to by myself at approx 1800hrs today asking her to nominate someone to mediate between herself and ex, but she refused ex having contact with children till this is resolved at Court in 2 weeks' time. This was from Solicitor's advice. The informant (George Randall) was updated about this and this could be reason behind call,"* Police IMR, (paragraph 7.39).

2.46 It appears that Police Officers visited George Randall on this day because:

> "*There is an entry on PROtect that relates to Fiona Johnson's harassment stating that 'Police attended on 28th April and George Randall was verbally warned by Police,'"* Police IMR, (paragraph 7.37),

2.47 On 03/05/11 Children's Social Care were contacted by their legal department because the judge, hearing the residence order application on 26/04/11 had asked that enquiries be made into Olivia's

> *"circumstances and to report by letter to the Court by the 10th May 2011,"* Children's Social Care IMR, (paragraph 4.25).

2.48 On 04/05/11 Fiona phoned Police to say that George continued to harass her by phone and text, she said she was distressed and angered by the contact and wanted it to stop. Police Officers visited her and a statement of complaint was taken from Fiona. A DV1 was completed and assessed as "medium" risk.

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[7] PROtect is a computer software program used by the public to record incidents of domestic abuse

[8] PNC is police national computer. This decision was correct in terms of a local order in force at the time though this has since been changed and this situation would now be put on the PNC.

[9] Storm is Essex police's command and control system which logs initial contacts and calls

This one was shared with Social Care and health, but not until 26/05/11. Fiona said she had received 14 voicemails the previous day from George plus 70 texts. Fiona would not give up her phone as evidence though she agreed to record every message and that she would make this available for the Police Officer the following day. Carol (in interview) told me that Fiona then spent hour's handwriting the texts onto sheets of paper.

2.49 The Police IMR for this Domestic Homicide Review failed to include the following information from the IMR provided by the Police for the serious case review.

> *"Fiona…told the Officer…that Randall had grabbed her throat about 5 and half years ago. Also, that he had thrown a ladder at her and held a knife to her leg,"* Police SCR IMR (paragraph 7.41).

2.50 She further went on to say to the same Police Officer that

> *"she is very frightened and afraid of further injury and violence and the level of abuse is increasing".*

2.51 On 09/05/11

> *"The Officer dealing ……. put in an arrest request to the local Police station for George Randall to be arrested for breach of the Non-Molestation Order. An attempt to arrest him was made later that morning but he was not at home. …… requested via Storm that a further attempt be made later that evening. A further recording reveals that when Officers did call at George Randall's address, they had seen a note stating he was not home until Friday. Further attempts were made to arrest without success,"* joint chronology, (09/05/11).

2.52 On 10/05/11 a social worker sent details to the local authority legal team about the case in an email which was passed onto the Court saying that the department had been involved with the family since 2009.

2.53 On 14/05/11 a Police Officer visited Fiona to update her about the progress of the complaint. The records suggest that Fiona wanted to "retract her statement". She did this the next day at Police Station 1 because she said her relationship with George was improving.

2.54 On 16/05/11 George went to the Police station to be arrested for breach of the Non-Molestation Order. He answered "no comment" to questions.

> *"At the conclusion of his interview advice was sought from a CPS Lawyer who ultimately advised based upon the available evidence 'no further action,"* Police IMR, (paragraph 7.42).

2.55 On 17/05/11 the Police Domestic Abuse Liaison Officer upgraded[10] (DALO) the DV1 completed about the incident on 27/04/11 from "standard" to "medium" and added the following to the form:

> "*There are a number of previous incidents involving this couple, and there were 3 incidents reported in April 2011 alone. George clearly shows little regard to the Court order and is still causing problems for Fiona. There are identifiable risks of serious harm and George has the potential to cause serious harm, but is unlikely to do so unless there is a change in circumstances,"* Police SCR IMR, (paragraph 7.37)

2.56 On 25/05/11 Fiona contacted the Police to say that George was making threats. Fiona did not want Police to visit her that day but agreed that an Officer could visit her after 9pm. She was interviewed with her agreement on 27/05/11, the delay being caused by the Police Officers being called to emergencies.

2.57 On 27/05/11 the health visitor and Gemma's school nurse received the DV1 regarding the incident on 04/05/11, over three weeks before. On the same day Fiona made a statement of complaint to the Police saying that she had received over 100 texts from George between 20th and 25th May 2011. Some were about contact but others were derogatory.

2.58 On 28/05/11 a Police Officer, EP2 was allocated the case of Fiona. He explained to the IPCC report author that he was unable to see Fiona because he was assigned to duties out of the County and wasn't able to come back to the case until 31/05/11 because of night shifts and emergencies.

> *"His assessment of the text messages was 'nothing leapt out at me that showed the texts were overly aggressive or required urgent attention… the majority seemed to be about access to and visiting their daughter,'"*
> Police IMR, (paragraph 7.44)

2.59 EP2 recorded the offence as "breach of Non-Molestation Order". A DV1 was completed but not entered onto the system until after the deaths of Fiona and Olivia, 10 days later. He detailed his shifts, to the IPCC report author, and stated that he was not able to progress the case until after his rest days on 3rd, 4th and 5th June.

2.60 On 31/05/11 Children's Services out of hours service completed a contact record stating that Police had contacted them on 27/05/11 about an incident that took place on 04/05/11. The out of hour's worker recorded that:

[10] It is part of the police reviewing mechanism that DALOs assess all DV1s and consider the appropriateness of the grading by the police officer

"*It is recorded that Fiona Johnson and George Randall split up around three weeks ago. There is currently an issue in relation to child contact and on the 21st April 2011 'W' County Court issued a Non-Molestation Order for George Randall not to harass/pester Fiona Johnson. Between the 21st and 28th April George Randall has contacted Fiona Johnson on 70 occasions by text message. Police attended on the 28th April 2011 and George Randall was verbally warned by the Police. Since the 28th April George Randall has sent a further 21 text messages and on the 30th April rang and left 12-14 voicemail messages.*
Police Decision: medium risk breach non-molestation NFA'd and DV letter sent. On the report the risk assessment questions have been completed where Fiona Johnson says that she is very frightened and afraid of further injury and violence and the level of abuse is increasing," Children's Social Care IMR, (paragraph 4.28).

2.61 On 01/06/11 the Police Officer allocated to Fiona recorded that he was unable to make progress because:
"he is on night shift, and could not progress the case as he was performing duties at Hospital1. He wrote that he had obtained a copy of the non molestation order, and needed to look through 15 pages of text messages and calls to see which are relevant for the order," Police IMR (paragraph 7.44)

2.62 In the early hours of 06/06/11 George arrived at Fiona's house and held her, Olivia and Gemma hostage. He had a shot gun. Gemma managed to escape by jumping out of a window. She went to her father's house and he telephoned the Police. After a short siege gunshots were heard and Police entered the premises to find Fiona and Olivia dead and George seriously injured.

2.63 The directions meeting regarding the application for residence and specific issue orders should have taken place later that day but the Court were informed of the deaths of Olivia and Fiona.

3. ANALYSIS

3.1 There is no mention thus far in this report or any IMRs of the gun used in the attack. Information provided by the Police SCR Panel representative has revealed that it was not legally registered and the Police had no knowledge of George having access to any guns.

3.2 There are no records anywhere else about a gun and it is not included in Fiona's application to Court for the Non-Molestation Order.

3.3 Essex Police's Domestic Abuse Policy now includes the requirement for a firearms check to be completed to establish if there are legally held firearms or shotguns in respect of Domestic Abuse incidents. This would not have protected Fiona or Olivia had it been in place in 2011 as the firearm was not registered.

3.4 In 2011 the Home Office found that more than one in four women in England and Wales aged 16 years and over had been affected by Domestic Abuse at some point in their lifetime. The evidence from research suggests that on balance women are the main victims and survivors of Domestic Abuse. Munro (2011), found that:

> *"there are 120,000 victims in any year who are at high risk of being killed or seriously injured as a result of Domestic Abuse; 69% of high risk victims have children," (paragraph 2.20).*

3.5 In Essex in 2011 there were 28,000 recorded incidents of Domestic Abuse; nearly 600 per week on average, 71% (382) of them involving children.

3.6 This analysis will consider the practice of the Police over the three years, Children's Social Care and will then consider the following:

- The application to Court was a key moment
- Workers were unaware of the extent of the Domestic Abuse
- Incidents are assessed in isolation and gradings in DV1s are not dynamic
- Why was Fiona perceived as "refusing to co-operate"?
- Why did Fiona not access the services that were available to support her?
- The role of Courts and Solicitors
- Developments and planned changes in Essex

Police

3.7 Police were involved with Fiona at various times in 2009 and 2011, as well as on one occasion in 2010. Police contact with Fiona and George escalated in April and May 2011. Although the Police Officers attending the scenes in 2011 completed DV1s and processed them the Police force failed to notify other agencies about these events, (apart from one notification which took three weeks to arrive). This meant that no other agency had an opportunity to consider whether this escalation may have indicated a significant rise to the risks faced by Olivia, Gemma and Fiona.

2009

3.8 The Police dealt with two incidents in the same week in April 2009. They ensured the protection of the children by taking them to the home of a relative and they made a referral to Social Care for a child protection investigation.

3.9 It is unclear whether or not they completed one or two DV1s on these incidents. Police records suggest that only one was completed whereas the health visitor received two notifications, Social Care only record receiving one.

3.10 Carol told me that at George Randall's trial a witness described Fiona "cowering" behind a counter. Serious threats were made including talk of "killing" Fiona, (as evidenced by the recording of the 999 call). Gemma, then aged seven, and Olivia aged one were still not in bed at 2.25 a.m.

3.11 Given that all this happened it may have been more appropriate for Police to have taken tougher action than they did against George, who was arrested and then released. These events should have resulted in a second referral to Children's Social Care for child protection consideration.

2010

3.12 There are two incidents of note in 2010, neither of which is as significant as the events in 2009 or 2011.

3.13 In January 2010 Social Care "completed" the initial assessment, which had consisted of a visit to Fiona and her children by a social worker in April 2009. "Completed" means that the records were written up and "signed off" on the computer by a manager.

3.14 In November 2010 ambulance staff and Police Officers went to the family home because George had threatened to harm himself, Fiona and the children were next door and Fiona and George were said to be drunk.

3.15 Once he had calmed down the professionals left the scene. Because he had been threatening to hurt himself as opposed to others the incident was not deemed to be a domestic violence event so no DV1s were completed.

3.16 This is an oversight. Whilst it may be true that the children were unaware of the incident (though records are unclear on this point), both adults were drunk. The event should have been considered to be potentially harmful to the children and a DV1 should have been completed.

2011

3.17 Whilst Police responded with alacrity to almost all of the telephone calls that they received from Fiona and George they failed to

- share most of the information with partner agencies,
- see a pattern emerging of increased stalking and harassment behaviour from George Randall,
- support Fiona when she wanted to help Police take action against George,
- record the details of what she was telling them.

Failure to share most of the information with partner agencies

3.18 The table (overleaf) details when the DV1s were completed, notifications made and how each DV1 was assessed.

3.19 There were ten incidents where Police Officers completed DV1s. Seven of these occurred shortly before the deaths of Fiona and Olivia and none of which were shared with partner agencies; health and Social Care, until after their deaths. This may be significant as these incidents came at the point of an increasing pattern of contact between Fiona, George, Police Officers and Social Care. The backlog of unprocessed DV1s did not just mean that other agencies were not aware of this increase but that the Police's own DALO[11] was not receiving information, and therefore not in a position to notice a pattern.

[11] Domestic abuse liaison officer

3.20 The failure to enter DV1s onto the PROtect system in a timely manner is clearly one of concern. Whilst it is fair to exonerate individual Officers from blame due to the backlog of 2,200 un-entered DV1s the same excuse cannot be given to the force itself who were given many warnings and opportunities to address this issue but failed to do so until shortly after the deaths of Fiona and Olivia. According to the IPCC report these include an HMIC[12] inspection report of 2007 which noted a significant backlog, an Essex Police review in 2009 which noted that there was an urgent need to input DV1 information into PROtect, and noted that the Domestic Abuse team should be properly resourced in the light of their increased workload since 2007. In 2011, an internal Essex Police report noted that the levels of staffing of Domestic Abuse professionals was at the same level as in 2005 despite a trebling of referrals. A further Essex Police review in 2011 recognised that there were significant issues regarding repeat victimisation within domestic violence investigations.

[12] Her majesty's inspectorate of constabulary

Date of incident and level of harassment	Incident	Date (and method) of sharing
4th March 2009 Assessed as standard	Argument at Fiona's home, requiring Officers to facilitate the safe return of Olivia to her mother	Shared electronically 4th March
6th April 2009 Assessed as medium	Incident at caravan where Gemma sustained small cut from thrown beer can	Telephone referral made to Social Care by Police Domestic Abuse Liaison Officer on 7th April. Shared by electronic notification on 9th April.
10th April 2009 Assessed as medium	Incident where Randall took Olivia from Fiona and conveyed her to his caravan	**Completed by attending Police Officers.** **Not shared as children not entered onto PROtect system**
7th November 2010 Not assessed	Randall self-harm incident	**Not shared as no DV1 completed**
14th April 2011 Assessed as standard	Olivia held by Randall and refused to return her to Fiona without Court order	**Completed by attending Police Officers.** **Not shared until 10th June 2011**
22nd April 2011 Assessed as standard 2 DV1s completed this day	Phone contact harassment	**Completed by attending Police Officers.** **Neither shared until 10th June 2011**
27th April 2011 Assessed as standard then raised to medium	Phone contact harassment	**Completed by attending Police Officers.** **Not shared until 10th June 2011**
4th May 2011 Assessed as medium	Phone contact harassment	Completed by attending Police Officers. Shared electronically 26th May 2011
25th May 2011 Assessed as standard	Phone contact harassment	**Completed by attending Police Officers.** **Not shared until 10th June 2011**

3.21 The IPCC report noted that there was a backlog of some 2,200 DV1 forms at the time that Fiona and Olivia were murdered. The report highlighted the general problem that this caused,

> *"The information contained within these forms is not only important to the Force but also other agencies with which the Force has agreements on sharing information*," (*paragraph 358),*

That report did not pass comment upon whether or not the failure to send the DV1s to partner agencies had any bearing upon the murders of Fiona and Olivia. It did note that a Social Care manager had stated to the author that

> *"it was likely that even if they* (Social Care*) had received notification of these incidents at the time they would not have taken any further action" (paragraph 281)*

3.22 It is right therefore to illustrate the problem of the lack of sharing of this information but it would be wrong to presume that this is the only issue worthy of note in this review.

Failure to see a pattern emerging of increased stalking behaviour from George Randall

3.23 Essex Police, as a whole, failed to recognise that George's harassment of Fiona was getting more pronounced in the seven weeks leading up to the shootings. It is difficult to say whether, at the time, Police Officers were individually aware of the history when they were interviewing her.

3.24 In 2011 Officers considered the content of George's text messages and found that it was not particularly threatening. This presumed that the content was the overriding factor of risk rather than considering what it felt like for Fiona to be inundated with texts (up to 70 per day) and telephone calls and the fact that George's behaviour could be considered to be stalking.

Failure to support Fiona when she wants to help Police take action against George

3.25 It is unlikely that Fiona was in fear for her life as, had she been, she had opportunity to tell Police Officers of this. Carol, her sister, told me that she did not believe that Fiona thought that George would murder her or Olivia; although Carol told me that she had said to Fiona that she was worried that George might carry out such an act. Fiona replied that she didn't think George was capable of doing such a thing.

3.26 There was a window of opportunity where Fiona was willing to assist the Police in their prosecution of George Randall; this was from 22/04/11 – 14/05/11. Fiona waited until the conclusion of the Court case (21/04/11) before tackling George's treatment of her. She sustained this determination for just over three weeks.

3.27 Carol told me that it was likely that George had continually been pleading with Fiona to forgive him, telling her how much he loved her and the children, saying that he had changed and playing upon her own insecurity.

3.28 By 14/05/11 he had succeeded. Fiona withdrew her complaint, George gave himself in to the Police (to be arrested for being in breach of the Non-Molestation Order) and the CPS decided that there was insufficient evidence to prosecute him.

3.29 Police had an opportunity to arrest George during this time; -they had issued an arrest warrant on 27/04/11- it appears that a Police Officer interviewed him on 28/04/11 and gave him a warning about his behaviour. Presumably because of the failure to put the arrest warrant on the PNC this Police Officer was unaware that he could have arrested George.

> *"If positive action had been taken Mr Randall could have been arrested, his account obtained and evidence recovered from his mobile telephone. It is likely that a further assessment of the evidence would then have been made by the Crown Prosecution Service…it may have served as a warning to him regarding his behaviour,"* IPCC report (paragraph 329).

3.30 A chief inspector told the author of the IPCC report that it was unlikely that, had George Randall been arrested, he would have been charged. Nevertheless the arrest would have been an example to George that Police were taking Fiona and his threats to her seriously and this may have encouraged Fiona to be more determined in her attempts to deal with him.

3.31 It is possible that an arrest, followed by a failure to charge, would have had the opposite effect.

3.32 The Police did allocate an Officer to Fiona's case shortly before her death and it is unfortunate that this Officer was unable to fulfil their role due to annual leave, shifts and other commitments.

Possible failure to record the details of events

3.33 The records of the Police are not consistent with the information given to me and the IPCC author by family members and neighbours.

3.34 There is no note in the Police IMRs of Police Officers recording the neighbour's view that she had been with Fiona when she told an Officer that

> *"Mr Randall had beaten her* (Fiona) *up lots of times," IPCC report, (paragraph 85).*

3.35 The Police did note that Fiona said that *"Randall had grabbed her throat about 5 and half years ago. Also, that he had thrown a ladder at her and held a knife to her leg,"* and that *"she is very frightened and afraid of further injury and violence and the level of abuse is increasing",*

3.36 Otherwise there is little detailed information about what was going on in the home.

3.37 This is in contrast to the community association IMR and the IPCC report which states that

> *"To prevent Olivia getting out via the front door or Mr Randall getting in Ms Johnson wedged a banister post between the bottom of the stairs and the door handle*," IPCC report, (paragraph 271).

3.38 Carol told me that she had been with Fiona and Police Officers in Fiona's house on two occasions in April or May 2011 when Fiona and the Officers had discussed the issue of the banister post, George having keys to the property and a panic alarm being installed but none of this is mentioned in the Police IMRs, suggesting that it was not recorded by Police Officers.

3.39 According to Carol the bannister was not in place when George Randall murdered Fiona and Olivia because another sibling had been staying with her that evening, had removed the post to go out saying that they would be back shortly.

3.40 The IPCC report says that

> "*Ms Johnson asked about a panic alarm and was advised* (by Police Officers) *it was quicker to use her mobile phone*," paragraph, 315.

3.41 How can it be quicker to dial "999", wait for the operator, ask for Police and give details as opposed to pressing a button? Furthermore it is unlikely that an attacker is prepared to wait while their victim passes the necessary information onto the Police.

3.42 The real reason was that her circumstances did not

"meet Essex Police criteria for the installation of such an alarm, as she was never categorised as high risk," IPCC report, (paragraph 308).

3.43 The Police Officer should therefore have told Fiona that she was not eligible for a panic alarm as she was not considered to be at high risk. This would have afforded her the opportunity to give further details to the Officer about what was happening to her.

Children's Social Care

3.44 Olivia was never allocated to a social worker in Children's Social Care beyond the one visit for the initial assessment in April 2009. All reports about the children from health professionals and school were positive and no professionals who visited Fiona at her home noted any concerns about the welfare of the children. Children's Social Care had no involvement with the family between May 2009 and April 2011.

3.45 Children's Social Care's involvement with the family was limited to an inadequate initial assessment in 2009 and a short report to Court in 2011 compiled without contacting the family.

3.46 The initial assessment was inadequate because it failed to collate any information from other agencies, did not challenge Fiona's view of events even though the social worker had evidence to contradict her version and took everything that she said at face value.

3.47 The report to the Court in 2011 failed to inform the Court that there had been no active involvement with the family since 2009.

3.48 The Police made an appropriate Child Protection referral to Social Care in 2009 and the child protection procedures used by Essex at that time state that this should have been followed up as a child protection enquiry. Had it been a core assessment would have been completed and thus more information would have been available to Social Care staff in 2011 and the case would have then probably received greater attention from those workers. This would also have allowed an opportunity to have assessed more fully the dynamics within the family.

3.49 The request from Court in April 2011, which would have been clearer had it been a request for a Children Act 1989, s7 or s37 report[13], should have received a more thorough response than a simple letter which implied a social worker was "allocated" and social workers had been involved "since" 2009.

[13] These are reports written by CAFCASS or the local authority in response to a request by a court for further information.

3.50 The decision to take no further action (NFA) following the phone call on 26/04/11 from George Randall to Social Care even though he made serious allegations, was a further missed opportunity to assess the vulnerability of Fiona and the children.

3.51 This NFA decision was taken by a manager using the following rationale:

> *"History suggests that father is the perpetrator of violence, not the mother as he alludes to and that is the reason a non molestation order has been granted. Father appeared angered with the current situation as he is not allowed contact with ex-partner or child," Children's Social Care IMR* (paragraph 6.26),

and was partly based upon the fact that the:

> *"previous initial assessment last year did not identify any concerns regarding mother's ability to protect", Children's Social Care IMR* (paragraph 6.27)

3.52 The allegations that George made were serious. There appears to be little doubt that if they were made by a professional some further action would have been taken.

3.53 Given that the information used by the manager to make this decision was based only upon the records on the computer, the decision was further compromised given that the information was significantly out of date. This was due to the fact that the assessment in April 2009 was "completed" in January 2010 – indicating that the information was more recent than it really was.

3.54 Furthermore whilst having identified that the:

- father is the perpetrator of violence,
- a Non-Molestation Order is in place, and
- father is angered with the current situation

the manager should have noted that this was an opportunity for the case to be thought of as "high risk" rather than warranting "no further action", and more consideration should have been given to the consequences of ignoring George at this time.

3.55 Police Officers were taking action in 2011. It is not the lack of action that is the problem but the reasoning behind the decisions that were being made.

GENERAL THEMES

The application to Court was a key moment

3.56 Fiona's application to Court for a Non-Molestation Order, and her separate application for a residence order and a specific issue order marks a significant point in this story. The application for the Non-Molestation Order resulted in details being told about the abuse, which could have been shared with Police and Social Care by the Court and her Solicitor. The application also made her more, not less, vulnerable.

3.57 Research evidence suggests that female victims of Domestic Abuse are more, not less, at risk when they make applications to Court. This is because it represents evidence to the perpetrator of a relationship breakdown which could be followed by the removal of his contact with his children. This referral should therefore have been seen as a trigger for more, not less, violence especially as a "change in circumstances" is one of the risk factors which forms part of the consideration between categorising a Domestic Abuse incident as 'Medium' or 'High' (see footnote 4).

3.58 Normally a Court would ask for a s.7 report or a s37 (Children Act 1989) report where a judge is concerned about a child's welfare. Had the judge requested such a report it is likely that Children's Social Care would have undertaken an assessment regarding Olivia's residence and contact arrangements (s7) or whether they needed to apply for a care or supervision order or provide services and assistance to the child and her family (s37). Essex Social Care's own procedures suggest that a s37 report should be in the form of a core assessment. However the judge requested, on 26/04/11:

> "*Essex CC do make immediate enquiry of child's* (Olivia) *circumstances and to report by letter to the Court by the 10th May 2011"* Children's Social Care IMR, (paragraph 6.28).

3.59 It is likely that the judge was concerned about Fiona and her children and wanted a quick response, (requests for s7 or s37 reports would normally take 8-12 weeks to be completed). However, the lack of the statutory formulation in the judge's request resulted in a missed opportunity for professionals to examine more thoroughly the situation and it allowed Children's Social Care to respond without any actual intervention. In the event the Social Care manager asked a social worker to review the case records and provide an overview of Children's Services involvement.

Workers were unaware of the extent of the Domestic Abuse

3.60 The descriptions of abuse in Fiona's Court application for a Non-Molestation Order, the pattern of daily life that the children have subsequently described, and the information given to the IPCC author by Carol and neighbours are far more graphic than anything that any professional recorded at the time. They also indicate a greater degree of domestic violence was occurring than any professional ever recorded.

3.61 As has been described before in this report, according to neighbours who spoke to the IPCC author and Carol, who spoke to me, Fiona was more forthcoming to Police Officers about her situation than the Officers' recordings suggest.

3.62 The children told me that arguments were a continual facet of their family life and that George was both physically violent and verbally threatening towards Fiona. Gemma said that these did not intensify in their severity towards the end of Fiona and Olivia's life but that they were more frequent. They have subsequently told their foster carers of serious incidents of abuse of Fiona, which were not recorded by any agency.

3.63 The information that the Police did record may have warranted a higher category than medium risk. The IPCC report suggests that the incident of 4th May 2011, where Fiona phoned Police to say that George continued to harass her by phone and text, should have been upgraded to high risk, from the medium risk assessed by the visiting Officer.

> *"Ms Richards (*who developed the DASH Risk Assessment on behalf of the association of chief Police Officers)*, states that domestic violence stalkers are considered the most dangerous and there is a high risk for future violence in such cases. In domestic violence cases stalking is a high risk factor for serious harm and homicide,"* (paragraph 339).

3.64 A category of high risk would also have ensured that the situation would have been referred to a Multi-Agency Risk Assessment Conference (MARAC) which is part of a coordinated multi-agency response to Domestic Abuse which shares information, determines whether the alleged perpetrator poses a significant risk and constructs a risk management plan. It would also have meant that Fiona was eligible for a Police alarm to have been fitted.

3.65 Agencies were either unable to provide a way to help Fiona and her children describe the true extent of the abuse occurring or professionals failed properly to record what they had observed and what had been told to them.

3.66 Research has identified that Domestic Abuse incidents are often assessed in isolation. A “stop-start” pattern is identified with some families receiving repeated assessments, but services are often withdrawn when families separate despite the fact that women and children are in an increasingly vulnerable position when they try to leave their partners. For many women the violence increases and often takes a different form, (for example as in this case, stalking) or commences following separation (Walby and Allen 2004).

3.67 There were ten incidents where Police Officers completed, or could have completed, DV1s. The risk was assessed as “standard” on five occasions and “medium” on three, one time a DV1 was not completed and another when the Officer rated the situation as “standard” it was later upgraded to “medium” by a Domestic Abuse Liaison Officer.

3.68 Despite the fact that many of these incidents occurred in April and May 2011 no-one had the opportunity to realise that the escalation may indicate more risk to Fiona and the children because the incidents weren’t entered on the system in a timely fashion. In fact, the application to Court that she made to protect herself and the children was assessed by practitioners as evidence of her being able to better protect herself and thereby reduce the risk to the children whereas, as Walby and Allen’s research suggests, this act made her and the children more vulnerable.

3.69 The definition of “medium” contained in the DV1 form contains the following:

> *“the offender has the potential to cause serious harm but is unlikely to do so unless there is a .... relationship breakdown,”.*

3.70 However the assessment was not upgraded to “high” when agencies found out about the Court case. This appears to be because there is no system in place to allow this to happen and professionals appear to believe that the application to Court makes the children less, not more, at risk. The definition for “high risk” includes:

> *“There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious.”*

3.71 This well describes the risk that, with hindsight, we now know Fiona and Olivia were facing.

3.72 Information about the situation is stored on computer but there does not appear to be a system in place for revisiting the assessment when further information arrives, other than a further Domestic Abuse incident taking place. The system is predicated upon “incident” and not “information” – a fact that is relevant to this case because the impending separation of George from his child (caused by Fiona’s application to Court) was a piece of “information” that should have heightened the awareness of practitioners to her vulnerability. It was the “change in circumstances” that increased her risk from “medium” to “high”. The systems in place do not allow this reassessment to take place; the current method of risk assessment for Domestic Abuse incidents can be seen as static when it should be dynamic.

3.73 Therefore the Panel will recommend that the victim and their children, not the incident, should be considered to be at “standard, medium or high risk” and that a system be created to ensure that re-assessments are undertaken as further information is received.

Why was Fiona perceived as “refusing to co-operate”?

3.74 It is difficult to say for certain what individual Police Officers knew about the level of violence and threat that Fiona was facing. The recordings on file contain little detail. This is in contradiction to what Carol and neighbours told the IPCC author and me and the information contained in Fiona’s application for the Non-Molestation Order.

3.75 Farmer and Owen’s (1995) research suggests that the Domestic Abuse itself may account for many mothers’ seemingly unco-operative behaviour and that confronting families with allegations of abuse could compound the victim’s vulnerable position.

3.76 A mother’s capacity to look after her children is affected by the severity of the violence she experiences and the tactics of the perpetrator may significantly undermine her relationship with her children and her ability to parent.

3.77 Fiona was able to ensure that her daughters stayed with her, - and she retained regular contact with their siblings - Gemma succeeded at school and Olivia developed well and reached all her milestones. All references by professionals to Fiona in the reports were positive and there is no reason to believe that she was doing anything other than behaving in, what she believed, were her Children’s best interests.

3.78 In 1998 (Keys and Young) noted that women experiencing Domestic Abuse were more likely to deal with the issues themselves or talk to family and friends rather than seek outside support due to barriers such as fear, isolation, lack of support and shame.

3.79 It appears to be the case that society expects the victims of Domestic Abuse (mostly women) to be those who shoulder responsibility for assisting the state in prosecuting the abuser and keeping themselves and their children safe from harm.

> *"According to Pat O'Malley, 'Neo-liberal agendas of individual responsibility and 'activity' foster devolution of crime prevention to the citizenry," Hoyle (2008).*

3.80 O'Malley's statement may be more appropriate for an academic text but nevertheless one which points to the same issue; the focus should not be on Fiona having to be pro-active in prosecuting George.

3.81 The same author, (Hoyle) in the same article, goes on to point out that:

> *"in the UK, the risk management techniques are directed firmly at helping victims to reduce their risk of victimisation........ The perpetrators are not encouraged to be accountable for their behaviour",*

Why did Fiona not access the services that were available to support her?

3.82 Carol told me that she discovered that Fiona had some leaflets[14] about support services for victims of Domestic Abuse in a wardrobe at her house. These may have been given to her by Police Officers, sent to her by a social worker or she may have found them in the community. There are no records, or family knowledge of Fiona accessing these services.

3.83 Carol told me Fiona was just worn down by George's continual harassment, promises to change and declarations of love to her.

3.84 Domestic Abuse usually involves a mixture of physical and psychological violence including emotional abuse, constant criticism, undermining and humiliation (Hester and Radford 1995), with consequent, profoundly negative effects on women's mental health. There is considerable evidence that women exposed to Domestic Abuse suffer a loss of confidence, depression, feelings of degradation, problems with sleep and increased isolation, and use medication and alcohol more frequently (Casanueva et al. 2009). Holt and colleagues' (2008) review of the literature identified between one third to two thirds of abused women experience post-traumatic stress disorder, low self-esteem, depression and anxiety.

3.85 Given these emotions, George's pressure and the not inconsiderable demands of being a single mother it is no surprise that Fiona failed to ring the numbers on the leaflets.

[14] There are 83 contact numbers for domestic abuse services across Essex.

The role of Courts and Solicitors

3.86 Fiona did tell her Solicitor in some detail about the abuse. Her application to Court for the Non-Molestation Order contained graphic detail of the violence that she was suffering including being dragged by her hair and, in the process losing some of it.

3.87 This information would have alerted Essex Police and Social Care to the fact that Fiona was at a greater risk than had been assessed. The application concerned the judge so much that she requested an immediate response from Social Care. Yet neither the Solicitor nor the Court shared that information with professionals.

3.88 Enquiries to the Law Society and the Solicitors Regulation Authority suggest that Solicitors are not required to pass significant information about adult and child vulnerability to Police or Social Care. They are privately employed not public servants and not subject to any requirements of disclosure. However Fiona's Solicitor stated to the IPCC author that:

> *"if Essex Police had requested a copy of the statements he had taken from Ms Johnson he would have provided them with her consent". IPCC report (paragraph 259).*

3.89 Essex Police do not request statements from Solicitors where Non-Molestation Orders have been issued.

3.90 Maybe a more proactive approach from the Solicitor would have been better - perhaps suggesting to Fiona that it may help protect her and her children if this information had been made available to the Police and Social Care. The information was also known to the Court and the Panel are less sympathetic to their failure to pass this on. The Panel notes that *Working Together to Safeguard Children*[15] makes no mention of the role of judges, magistrates and Court officials in protecting children and believes that to be an omission.

3.91 The IPCC report states that:

> *"the Force needs to consider, with Court 1 and Essex County Council, mechanisms that could be put in place to ensure that this type of information can be shared appropriately with relevant agencies", IPCC report (paragraph 356)*

The Panel endorses this view.

[15] Government guidance detailing how child protection is managed in England.

4. DEVELOPMENTS AND PLANNED CHANGES IN ESSEX

4.1 In 2012 Police and Social Care in Essex alone received 30,000 referrals for Domestic Abuse. Identifying those most at risk will remain difficult however much we seek to improve practice and systems.

4.2 There are a number of initiatives in Essex that make the task more manageable. One is a pilot project that ran in south Essex from October 2011 to February 2012. DV1s were sent by the Police to secondary schools (via Essex County Council) in addition to the normal partner agencies. The intention was to alert those teachers in a position to help children and young people discuss their home situation. It also gave teachers background information that may help to explain a child's absence, poor attainment or behaviour.

4.3 The project has been positively evaluated and the next steps are being considered. The practice of schools being notified regarding Domestic Abuse is being considered at a national level so the feedback from the South Essex pilot as well as others across the country is being used to develop a national picture and examples of best practice. The present rate of DV1s represents an average of 40 per school per year. These numbers are manageable according to the head-teacher who has been co-ordinating the pilot.

4.4 Both Gemma and her sibling, said that they thought that this is a sensible suggestion.

4.5 Gemma also said in interview that she had seen Police Officers on about three occasions and they had never spoken to her about the abuse that she had been witnessing.

4.6 The reluctance of professionals to include children and young people in their assessments is a recurring problem; professionals have been reminded of the need to listen to children in many enquiries. The Panel support the school project because it is far more likely that a child will tell a teacher or a school friend about their problems than any other professional.

4.7 There is much focus upon the Police and Children's Services in this report. Both organisations have made changes that will improve their service to victims of Domestic Abuse in the future.

4.8 Children’s services have now significantly improved their systems and practices, have been judged by Ofsted to be “adequate” (compared to “inadequate” at the time of these events) and have a completely new senior management team in place.

4.9 They have created three posts, one assistant manager and two social workers dedicated to making assessments from information received in domestic violence notifications and information already held. By focussing attention upon previous concerns as well as new incidents the “start again syndrome” described by Marion Brandon (2008) should be avoided.

4.10 Had these initiatives been in place in 2011 (and the DV1s been passed on promptly), Gemma’s head teacher would have received six notifications in the eight weeks preceding the murders of her mother and sister. This would have meant that there were people near to Gemma who may have given her the opportunity to discuss with them what was going on at home. As well as this being a therapeutic opportunity it may have provided further details that would have been useful to social workers and Police Officers. At the same time the dedicated social workers in Children’s Social Care would have realised that a pattern was emerging and may have taken further action.

4.11 A letter sent to the Panel on 13/11/12 by an Assistant chief constable, Essex Police – included as appendix four, states that Essex Police have

- reduced the backlog of DV1 notifications,
- increased the number of staff working on Domestic Abuse cases,
- increased training on domestic violence and stalking,
- created a Domestic Abuse intelligence team who carry out intelligence checks, previous calls checks and PNC checks at the time a Domestic Abuse call is received and who inform the Officers attending Domestic Abuse incidents of these matters,
- created a central referral unit for Domestic Abuse which is responsible for co-ordinating the referral and risk management processes for Domestic Abuse, these staff members will engage in ‘real time’ dialogue with Officers attending incidents.
- developed an electronic DV1 form which replaces the 20 page paper form,
- invested in training to ensure that Officers obtain good quality statements
- required Officers to keep victims of Domestic Abuse updated of the progress of investigations.

4.12 These developments are happening alongside the development plans for a multi-agency hub, which is being developed as part of the Whole Essex Community Budget. The plan is to initially include:

- IDVA service (Independent Domestic Violence Advocacy)
- Project Manager
- Police Officers
- Children Social Care
- Safer Places

4.13 Hub staff will act as gatekeeping/case co-ordinator and link with other agencies/resources as well as completing multi-agency risk assessments.

4.14 In addition funding has been made available via the whole Essex community budget. This will develop a new way to deliver radical new approaches to public services.

4.15 Downton District Council will be implementing both of the following initiatives over the next twelve months.

Initiative 1 – IDVA support for all High Risk Survivors in the District (New Post with Victim Support)

4.16 Independent domestic violence advisors specialise in offering support to high risk victims of Domestic Abuse.

4.17 Currently in Essex, due to restricted funding and resources, the IDVA service, provided by victims support under contract to Essex Police, only take referrals where-

- The victim is over 18
- The perpetrator has been charged with a domestic crime
- The DASHH (Domestic Abuse Stalking Harassment and Honour Based Abuse) assessment has been confirmed as high risk

4.18 This equates to approximately 25% of cases that the Police confirm as high risk. By changing the criteria the IDVAs will, in future, be allocated to all victims assessed as high risk.

4.19 Evidence suggests that a combination of IDVA support and other initiatives has a 60% success rate in reducing the incidence of Domestic Abuse.

Initiative 2 Volunteer support for some medium risk survivors

4.20 This will enhance the existing service provided by Victims support under contract to the Home Office. Under this contract victims of particular crimes are offered help from Victim Support. Referrals can come from the victim directly or from any agency, but the majority of referrals received by victim support come from the Police. A victim can choose to decline the service offered. The support offered is not specific to victims of Domestic Abuse.

4.21 Victim support will be expanding this service using volunteers to all medium risk survivors of Domestic Abuse not just those who are victims of a crime (currently only victims of a crime receive support). The volunteers will tailor support for each victim and offer signposting and referring to other agencies, advocacy, and emotional support to the victim.

4.22 The description of the abuse in Fiona's application to Court included the comment that her hairdresser had thought that the hair that she had lost had been caused by alopecia, rather than abuse. The Domestic Homicide Review Panel considered this issue and gave some thought to the role of hairdressers in recognising Domestic Abuse. They asked other LSCBs for their experience and thoughts and these are included as appendix five to this report. This report contains a recommendation about this.

5. CONCLUSION

5.1 The legal system failed to protect Fiona and her children. The application to Court and the potential separation of Olivia from George appears to have been the trigger for the murders. The Court was given information that should have caused Essex Police and Social Care to re-assess the risks posed to the family but this information was not passed to either agency.

5.2 The Panel takes the view that Fiona should have been supported in helping the Police. There appeared to be no attempt to encourage her, or her children, to tell professionals about what was really happening; as difficult as this may have been.

5.3 Case reviews should address the question whether the event that led to the person being injured or killed could have been prevented or predicted. It seems likely that had:

- Police shared DV1s in accordance with procedures,
- professionals recorded events in detail,
- the information known to Essex County Court and Fiona's Solicitor been passed to relevant professionals,
- anyone talked to the children about what was happening,
- the allegations made by George in May 2011 led to a thorough assessment,

then Fiona, Gemma and Olivia would have been considered to have been more at risk than they were. However, even had that been the case, we cannot be sure that there would have been any action which could have been taken with or without Fiona's agreement, that would have saved the lives of Fiona and Olivia and protected Gemma and sibling from the consequent trauma.

5.4 The failings in the case are an inadequate understanding of the dynamics of Domestic Abuse, across partner agencies, illustrated by:-

- The emphasis on Fiona's perceived refusal to co-operate
- The fact that the Non-Molestation Order increased the risk not, as perceived by many professionals, decreased it
- The lack of involvement of children
- Perceiving Fiona's unwillingness to seek help or give evidence against George being a sign of culpability rather than one of vulnerability
- A failure to notice an escalation in George Randall's threatening behaviour.

5.5 It will not be possible to compile simple recommendations to address these complex problems. Furthermore this situation has been subject to three review processes: this Domestic Homicide Review, a Serious Case Review and an IPCC report. Any developments should therefore be based upon a final analysis of all three reports and co-ordinated by the Community Safety Partnership with other appropriate boards.

6. RECOMMENDATIONS

6.1 Improvements in protecting adults and children from Domestic Abuse in Essex can be achieved by:

1. Creating a system whereby the victim and their children are assessed against risk for an individual incident but that this does not stand alone and indeed on each occasion where fresh information is received forms the latest instalment of information that feeds into a continuing assessment of risk overall as regards the victim and their children. As a consequence the overall risk is subject of constant review and refinement against the standard, medium or high risk criteria
2. Creating a system whereby DV1 categories can be changed when further information becomes available, as opposed to the present system which is predicated upon events
3. Better liaison between agencies and Domestic Abuse voluntary agencies to discover better ways of encouraging victims to assist Police in gathering evidence.
4. DV1s assessed as High or Medium Risk are routinely sent to the school, so that the school is aware of any concern or risk to the child.
5. Ensuring that Essex Police continue to work with the County Court to ensure that information pertaining to any concerns about children are appropriately passed on.
6. Practitioners being reminded that separation and/or loss of contact with child/ren in Domestic Abuse situations increases risk rather than diminishes it.
7. Police must review their grading of risk when in receipt of a Non-Molestation Order or other change in circumstances
8. Training Police Officers to better record the detail of Domestic Abuse incidents and the conversations that they have with family members
9. Arrest packages being acted upon regardless of individual Officer's time off or other duties to ensure that there is not a lengthy delay in following an action through.
10. The Community Safety Partnership to consider ways in which they can build on engagement with the community to assist victims of Domestic Abuse.
11. Map pathways of support for perpetrators and make this known to agencies.

Furthermore:

12. Where appropriate, when an event determines that a Serious Case and Domestic Homicide Review be conducted, the processes should be joined and a joint Panel be convened.

The implementation of this Action Plan will be monitored by the Downton Community Safety Partnership.

Early versions of this report, drafted by the previous author, contained information relating to the problems that the Panel had experienced in conducting this Domestic Homicide Review. The Panel believed that this was not relevant to this case but that it contained useful information regarding the conduct of future Domestic Homicide Reviews and that involved the death of a child. This information contains recommendations about the DHR process and will be used by Essex agencies to prepare for future Domestic Homicide Reviews.

DOWNTON ACTION PLAN

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion & Outcome
1.Creating a system whereby the victim and their children are assessed against risk for an individual incident but that this does not stand alone and indeed on each occasion where fresh information is received forms the latest instalment of information that feeds into a continuing assessment of risk overall as regards the victim and their children. As a consequence the overall risk is subject of continuing review and refinement against the standard, medium or high risk criteria	Countywide	Review Force Domestic Abuse Policy	Essex Police	Interim Domestic Abuse Policy in Place	July 2011	7th July 2011 Interim Policy in Place
			Essex Police	Bulletin reminder to all Staff		22nd July 2011 re interim policy and emphasising key points.
			Essex Police	Updated Full Domestic Abuse Policy	Sept 2011	26th Sept 2011 policy in place. 2.5.2013
					August 2013	Following recent thematic inspection from HMIC, Essex Police will be undertaking adjustments to the current DA policy. The next iteration of the policy will reflect this recommendation.
		A Domestic Abuse Intelligence Team (DAIT) be established within the Force Information Room	Essex Police	Establish Team. Setup the team of 10 Officers, trained and operational.	Aug 2011	Aug 2011. DAIT formed (10 Officers). Established within Force Information Room. (Appendix 15 DAIT TOR attached)

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion & Outcome
		Setup weekly Domestic Abuse conferences within the Police.	Essex Police	Identify who needs to be involved. Setup weekly Conferences	Sept 2011	Sept 2011. A weekly Domestic Abuse conference call has been established and is attended by senior Officers of the relevant departments within Essex Police. All high risk cases are reviewed as are a range of performance aspects.
		Setup risk management conference process for considering and agreeing tasking of high risk cases.	Essex Police	Identify who needs to be involved. Setup weekly Conferences	Sept 2011	Sept 2011. Risk Management process established with the Head of Public Protection. Fortnightly meetings held with senior Officers to consider and agree tasking in respect of high risk cases of Domestic Abuse and public protection.
2. Creating a system whereby DV1 categories can be changed when further information becomes available, as opposed to the present system	County wide	To coordinate the referral and risk management processes for Domestic Abuse and Vulnerable Adults. To ensure	Essex Police	Setup a Central Referral Unit (CRU)	Nov 2012	5th Nov 2012. CRU operational. As above. The next iteration of the policy will reflect this recommendation.

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion & Outcome
which is predicated upon events		that Domestic Abuse referrals are accurately recorded, graded, fully researched with relevant information shared with social service departments and other relevant agencies.				
3. Better liaison between agencies and Domestic Abuse voluntary agencies to discover better ways of encouraging victims to assist Police in gathering evidence.	County wide	To design a 'hub' as part of the CRU phased development whereby multiple agencies are co-located with the common aim of responding effectively to Domestic Abuse incidents.	Whole Essex Community Budget Team (Essex Police, County Council & Downton District Council)	Design Hub	Sept 2012 Jan 2013	For January and February 2013, the hub (MASH) has been running for 38 days and currently, 96 victims have engaged with non Police staff in the hub (Safer Places) that would not engage with the Police. 60 % of these have been provided with extra support. 53% of these have been referred to other agencies, and, 7% went into a refuge. This

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion & Outcome
						is great outcomes for the new hub and Whole Essex Community Budget WECB as this means that 96 victims may have not been given any support and the potential for Domestic Homicides, although always an unknown quantity, could have prevented one/some. 3rd May 2013 Work continues with the Head of Children's' Services and other agencies to progress the MASH project further.
4. DV1s assessed as High or Medium Risk are routinely sent to the school, so that the school is aware of any concern or risk to the child.	County wide		Whole Essex Community Budget Team (Essex Police, County Council & Downton District Council) **Essex Police & Essex Safeguarding Children's Board** ***(recommendation from SCR)***	Develop phase 2 of the original pilot to build upon phase 1. 1. Pilot Phase 2 Triaging of Appropriateness of sharing DV1s 2) Further training for School Safeguarding Leads 3) Triaging system for DV1s	March 2014	Phase 2 - This work now forms part of the whole Essex Community Budgets – MASH project. First PILOT - Report attached, Appendix 16

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion & Outcome
5. Ensuring that Essex Police continue to work with the County Court to ensure that information pertaining to any concerns about children are appropriately passed on. *	County wide	Establish multi-agency working group to identify and develop opportunities for improved information sharing.	Essex Police	Inaugural meeting of working group. Establishment of working information exchange protocols	April 2013	1st April 2013 Currently information relating to children within the family Court system who are from a Domestic Abuse situation is known to CSC and CAFCASS. The Section 47 and Section 17 checks are made with the Police, but it is not usual for Police to be involved further. Work is being done by DCI Johnson and DCS Coxall with HM Family Court to identify ways in which information can be shared. Within the children sphere a section 17 or 47 check is usually carried out by CAFCASS at the start of their involvement. Where a Section 47 check is made with CAIT it is recorded on PROtect, a review is being carried to update the process to ensure

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion & Outcome
						that Section 17 checks are also recorded on force wide systems. Section 17 checks carried out with the Vetting Unit will be placed on Intel and a process is to be agreed so that if the check is carried out on a high risk victim CRU are notified for addition review of safety to be carried out. Work is also being conducted with HMCTS exploring the feasibility of statements of victims used in support of successful Non Molestation Order applications are made known to the Police.
6. Practitioners being reminded that separation and/or loss of contact with child/ren in Domestic Abuse situations increases risk rather than diminishes it.	County wide	Joint Briefing presentations on the Reviews to partner organisations across the Safeguarding Adults, Safeguarding Children and,	Johnson DHR Chair & Olivia SCR Chair	Agree content of joint briefings Delivery	Oct 2013 Nov 2013 to March 2014	

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion & Outcome
		Community Safety Partnership arenas across Essex				
7. Police must review their grading of risk when in receipt of a Non-Molestation Order or other change in circumstances	County wide	1. Introduce receipt of Non Molestation Order in respect of a victim as a significant event in the ongoing Risk assessment process. 2. Seek to improve intelligence exchange between Essex Police and agencies engaged in the Civil Courts process.	Essex Police			2nd May 2013 As per recommendation 5 above work is being carried out in respect of family Court orders. A new process relating to Non-Molestation Orders is being discussed to standardise the process and ensure that the appropriate systems and reviews are carried out when an order is received by the Police
8. Training Police Officers to better record the detail of Domestic Abuse incidents and the conversations that they have with family members	County wide	In line with NPIA guidance all Police staff that take reports of Domestic Abuse are provided with Domestic Abuse Stalking & Harassment training.	Essex Police	DASH Training for all staff E-Learning for Support Staff and PCSOs Training of remaining Officers and new recruits	Ongoing This package forms part of their	All relevant staff/Officers (Police Officers including custody Officers and other specialist posts below the rank of Inspector and all Domestic Abuse specialist Officers and staff) have now received DASH training. April 2013. Those that haven't are either long term sick, maternity or

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion & Outcome
					induction	other abstractions.
9. Arrest packages being acted upon regardless of individual Officer's time off or other duties to ensure that there is not a lengthy delay in following an action through.	County wide	Adjust resources of DALO inputters over Bank Holiday periods Review the Downton District Arrest Package	Essex Police	Make budgetary provision	January 2012	Current DA Policy meets this recommendation. (Appendix 17 Extract from DA Policy attached) (The Downton arrest package has been rescinded)
10. The Community Safety Partnership to consider ways in which they can build on engagement with the community to assist victims of Domestic Abuse.	Local	Essex Police leading the pilot activity which will extend support to more high and medium risk in Downton and Another district. Put in place a Domestic Abuse Pilot with two initiatives specific to Downton (See 4.15 in main report): Initiative 1 – IDVA support for all High Risk Survivors in	Whole Essex Community Budget Team (Essex Police, County Council & Downton District Council)	Project/s developed - identified based on gap analysis	Jan 2013	Project Agreed and Expressions of interest go out.

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion & Outcome
		the District Initiative 2 Volunteer support for some medium risk survivors Request Expressions of interest from County wide Local Authorities In the detailed design phase now with a go-live date beginning July 2013. The additional support workers will be working out of the multi-agency hub at Essex Police HQ, managed by Police	Whole Essex Community Budget Team Essex Police	Expression of interest requested from each Local Authority CEO Recruitment of workers for both initiatives	March 2013 June 2013 July 2013	Two Local Authorities sign up to the Pilot March 2013 (both Initiatives)

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion & Outcome
		Project Manager. A Chief Inspector is co-ordinating the involvement of Social Care resources / expertise into the Hub. Develop a campaign with Hairdressers for Domestic Abuse sign posting to support services	Downton CSP in Partnership with Safer Places	Research existing schemes Access 'seed' Funding Application to PCC New Initiatives Fund (£1,000) Liaise with Hairdressers and pilot the project Critique project and encouraged take up /	Jan 2013 March 2013 10th May 2013 June 2013 June 2014	Unable to use an existing scheme due to permissions. Feb 2013 Developing Downton specific scheme with partners £1,000 Grant from High Sheriff Award Working with lead agency – Safer Places

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion & Outcome
				expansion		
11. Map pathways of support for perpetrators and make this known to agencies.	County wide	Essex Police will produce a draft during May and then partner consultation can start. Plan to develop the strategy with input from Prof Sherman's research but as a shorter-term activity likely to commence in the summer.	Whole Essex Community Budget Team (Essex Police, County Council & Downton District Council	The report is recommending averting uniform Police from dealing with these cases, with the proposal being that a dedicated team, with an enhanced level of training in Domestic Abuse, address the High Risk cases based on frequency, recent and gravity, to enable the Police to identify the top 50 perpetrators of Domestic Abuse across Essex, and focus on these. This approach is not dissimilar to the Integrated Offender Management approach. The dedicated team would be the Police	May 2013	Perpetrator strategy has been developed by Essex Police and focusses on prompt engagement with repeat DA offenders. Further multiagency work through the MASH is required to support this with 'perpetrator programmes' diverting them from criminal offending.

Recommendation	Scope of recommend ation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion & Outcome
				Officers from the Multi-Agency Strategic Hub, and these staff being replaced by Police staff (non Officers). The report is with Senior Police Officers and an outcome/feedback is expected May 2013.		
ASKs of the Home Office						
That a template be produced to ensure that both DHR and SCR IMRs use similar formats	National	National guidance on joint template	Home Office			
Where appropriate, when an event determines that a Serious Case and Domestic Homicide Review be conducted, the processes should be joined and a joint Panel be convened	County wide and/or National		Chair of Safeguarding Children's Board & Chair of Community Safety Partnership Home Office	Assessment at outset where a Domestic Homicide involves the death of child/children. Timescale of agreement for joint Panel	When a DHR takes place (formal notificatio n by Essex Police to CSP Chair)	

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Appendix one

1. TERMS OF REFERENCE AND METHODOLOGY

Introduction

This Domestic Homicide Review (DHR) is initiated by the District Community Safety Partnership in response to the death of Fiona Johnson in June 2011 and in accordance with the requirements of the Domestic Violence, Crime and Victims Act 2004.

The review will follow the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews issued by the Home Office in March 2011.

Purpose of the Review

It should be noted that DHRs are not inquiries into how the victim died or into who is culpable. That is a matter for Coroners and criminal Courts, respectively, to determine. Nor are they specifically part of any disciplinary enquiry or process.

The purpose of the review, then, is to:

- 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 on, and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate.
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

Scope of the Review

The review will:

- Seek to establish whether the events of 6 June 2011 could have been predicted or prevented.
- Consider the period of approximately two calendar years prior to the events, from the birth of Fiona's youngest daughter Olivia, who was killed along with her mother, subject to any information emerging that prompts a review of any earlier incidents or events that are relevant.
- Request Internal Management Reviews by each of the agencies defined in Section 9 of the Act, and invite responses from any other relevant agencies or individuals identified through the process of the review.
- Seek the involvement of the family, employers, neighbours and friends to provide a robust analysis of the events.
- Take account of other relevant inquiries or reviews, and specifically: the Coroner's inquiry; the Serious Case Review; the Child Death Review; the Independent Police Complaints Commission inquiry; and the criminal investigation.

- Produce a report which summarises the chronology of the events, including the actions of involved agencies, analyses and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where Domestic Abuse is a feature.
- Aim to produce the report subject to responding sensitively to the concerns of the family, the other inquiries and reviews being completed, the criminal investigation and the potential for identifying matters which may require further review.

Conduct of the Review

Timescales

The Overview Report will be completed bearing in mind other investigations that are underway. The expected completion will be to an agreed timescale.

Individual Management Reviews

Agency Involvement with the Victim, the Perpetrator and their Families

The review should include a comprehensive chronology that charts the involvement of the agency with the victim, the perpetrator and their families over the period of time set out in the review's terms of reference. It should summarise the events that occurred; intelligence and information known to the agency; the decisions reached; the services offered and provided to the victim, the perpetrator and their families; and any other action taken.

Analysis of Involvement

The review should consider the events that occurred, the decisions made and the actions taken or not taken. Where judgements were made or actions taken that indicate that practice or management could be improved, the review should consider not only what happened but why. Each homicide may have specific issues that need to be explored and each review should consider carefully the individual case and how best to structure the review in light of the particular circumstances. The following are examples of the areas that will need to be considered:

- Were practitioners sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic violence 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?
- Did the agency have policies and procedures for (DASH) risk assessment and risk management for domestic violence victims or perpetrators and were those assessments correctly used in the case of this victim/perpetrator? Did the agency have policies and procedures in place for dealing with concerns about domestic violence? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC?
- Did the agency comply with Domestic Abuse protocols agreed with other agencies, including any information-sharing protocols?

- 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?
- 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?
- When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?
- Was anything known about the perpetrator? For example, were they being managed under MAPPA?
- Had the victim disclosed to anyone and if so, was the response appropriate?
- Was this information recorded and shared, where appropriate?
- Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary?
- Were senior managers or other agencies and professionals involved at the appropriate points?
- Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?
- Are there ways of working effectively that could be passed on to other organisations or individuals?
- Are there lessons to be learned from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?
- How accessible were the services for the victim and perpetrator?
- To what degree could the homicide have been accurately predicted and prevented?

Individual Management Review Template

Introduction

Brief factual/contextual summary of the situation leading to the DHR including an outline of the TOR and date for completion:

- Identification of person subject to review
- Date of Birth
- Date of death/date of serious injury/offence
- Name, job title and contact details of person completing this IMR (include confirmation regarding independence from the line Management of the case)

Victim, perpetrator, family details if relevant:

Name	Date of Birth	Relationship	Ethnic Origin	Address

Include family tree or genera if relevant.

Terms of Reference

Contained within this document.

Methodology

Record the methodology used including extent of document review and interviews undertaken.

Details of Parallel Reviews/Processes

SCR – in respect of the child
IPCC – Independent Police Complaints Commission investigation underway
Internal Police investigation
Criminal Processes

Chronology of Agency Involvement

What was your Agency's involvement with the victim?

Construct a comprehensive chronology of involvement by your agency over the period of time set out in the review's terms of reference. State when the victim/child/family/perpetrator was seen including antecedent history where relevant. Identify the details of the professionals from within your agency who were involved with the victim, family, perpetrator and whether they were interviewed or not for the purposes of this IMR.

Analysis of Involvement

Consider the events that occurred, the decisions made, and the actions taken or not. Assess practice against guidance and relevant legislation.

Addressing terms of reference
Consider further analysis in respect of key critical factors, which are not otherwise covered by the sections above.

Effective Practice/Lessons Learnt

Processes already changed or identified by this organisation. Include any action plans.

Recommendations

Recommendations should be focussed on the key findings of the IMR and be specific about the outcome which they are seeking.

Family Involvement

The review will seek to involve the families of both the victim and the perpetrator in the review process, taking account of who the families wish to have involved as lead family members, and any other people the families think relevant to the review process.

Legal Advice and Costs

Each statutory agency will be expected and reminded to inform their legal departments that the review is taking place. The costs of their legal advice and involvement of their legal teams is at their discretion.

There may be a requirement to access independent legal advice on the part of the review team, and the team will seek funding of this advice from the Safer Essex Partnership and statutory partners.

Expert Witnesses and Advisors

We intend to consider consulting with the appropriate agencies and individuals to provide any additional information or advice as this becomes necessary arising from the report:

Other appropriate agencies and people may be identified through the course of the review and a list of people will be compiled, which may need additions during the course of the review.

Names and contact details will be held centrally by the Chair and involved in agreement with the Panel.

Quality Assurance

Quality assurance for completed DHRs rests with an expert group made up of statutory and voluntary agencies and managed by the Home Office. All completed Overview Reports and supporting documents should be sent to the Home Office (DHRENQUIRIES@hoMeoffice.gsi.gov.uk) and will be assessed against this guidance. The group meet on a quarterly basis to assess report standards as well as identifying good and poor practice and training needs. Further information about this group can be found at www.homeoffice.gov.uk.

Where reviews are assessed as inadequate, a summary of findings is sent to the CSP Chair who is responsible for ensuring the areas of concern are revisited and amended. The Home Office Quality Assurance Group will be responsible for assessing progress identified at a national level.

Following the quality assurance process, the Quality Assurance Group will inform the CSP of any outstanding issues and information on when the review can be published. Completed reviews should be published at a local level on the local CSP website. The Home Office page will also include examples of effective practice and updates on national learning and training.

The Home office Quality Assurance Group is also responsible for:

- Disseminating lessons learned at a national level and effective practice
- Identifying serious failings and common themes
- Communicating with the Media to raise awareness of the positive work of the statutory and voluntary agencies with domestic violence victims and perpetrators so that attention is not focused disproportionately on tragedies
- Communicating and liaising with other government departments to ensure appropriate engagement from all relevant agencies
- Providing central storage for DHRs to allow for clear auditing of review documentation and quick retrieval if required
- Requesting updates from local areas on actions taken following a review
- Reviewing decisions by CSPs not to undertake a DHR
- Recommending national training needs and working across government to ensure existing training is highlighted
- Recommending service needs to commissioners

Overview Report

The Overview Report should bring together and draw overall conclusions from the information and analysis contained in the IMRs and reports or information commissioned from any other relevant interests.

Overview Reports should be produced according to the outline format and template and as with IMRs, the precise format depends on the features of the homicide. The Review Panel will need to bear in mind the importance of keeping personal details anonymous within the final report and Executive Summary.

It is crucial the Chair has access to all relevant documentation and, where necessary, individual professionals to enable them to effectively undertake their review functions.

The findings of the review should be regarded as 'Restricted' as per the Government Protective Marking Scheme (GPMS) until the agreed date of publication. Prior to this, information should be made available only to participating professionals and their line managers who have a pre-declared interest in the review. It may also be appropriate to share these findings with family members as directed by the Chair, taking into account ongoing criminal proceedings.

As part of the terms of reference, the Chair should appoint lead individuals or agencies to take responsibility for engaging with family members and friends, and for responding to Media interest about the review, in liaison with contributing agencies and professionals.

Review Panel Action on Receiving an Overview Report

On being presented with the Overview Report the Review Panel should:

- Ensure that contributing organisations and individuals are satisfied that their information is fully and fairly represented in the Overview report.
- Ensure that the Overview Report is of a high standard and is written in accordance with this guidance.

Overview Report Action Plan

The Overview Report should also make recommendations for future action which the Review Panel should translate into a specific, measurable, achievable, realistic and timely (SMART) Action Plan (see page 68). The Action Plan should be agreed at senior level by each of the participating organisations.

The Action Plan should set out who will do what, by when, with what intended outcome. The Action Plan should set out how improvements in practice and systems will be monitored and reviewed.

Once agreed, the Review Panel should provide a copy of the Overview Report, Executive Summary and the Action Plan (hereafter referred to as 'supporting documents') to the Chair of the CSP.

Media and Communication

We will seek to agree a communication strategy that keeps the families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this.

The families will be offered a named person through whom they channel communication. The ideal would be to have one named person per family as a conduit for sharing information.

Before the release of any statement, the families involved will be contacted and the process will be fully explained to them, with any comments noted.

Agreement will be sought with them on their preferences on how and when they are kept informed.

A statement will be prepared for the Media, the wording to be agreed between Chairman of Downton Community Safety Partnership and Chair of the Panel. Timing for the release of any statement to be agreed, also the named contact for the Media. It will be paramount that there is clear agreement that no other person has authorisation to be in contact with any form of Media without prior agreement with Chairman of Downton Community Safety Partnership.

Disclosure and Criminal Proceedings

Disclosure is one of the most important issues in the criminal justice system and the application of proper and fair disclosure is a vital component of a fair criminal justice

system. All disclosure issues must be discussed with the Police SIO, the CPS and the HM Coroner's representative as appropriate.

There may be homicides where the investigator believes that a third party (for example, a local authority or Social Care) has material or information which might be relevant to the prosecution case. In such cases, if the material or information might reasonably be considered capable of undermining the prosecution case or of assisting the case for the accused, prosecutors are asked to take steps they regard as appropriate to obtain it. This may include applying for a witness summons causing a representative of the 'third party' to produce the material to the Court.

Dependent on the case, material gathered in the course of a DHR may be capable of assisting the defence case and would almost certainly be material that the defence would seek to gain access to. If a DHR is being conducted parallel to a criminal investigation the disclosure Officer will be obliged to inform the Prosecutor and any interviews with other agency staff, documents, case conferences etc may all become disclose able. It is the responsibility of disclosure Officer to link in with Panel Chair.

Below is a suggested process for managing issues of disclosure within a DHR:

- In all cases of domestic homicide, even when the suspect subsequently commits suicide, a criminal investigation will be commenced.
- Once an investigation has been commenced, the relevant CSP should be informed in order that they may consider commissioning a DHR.
- Where the evidence indicates that the suspect has killed themselves the case will be referred to the Coroner and a file will be prepared. In these circumstances it is appropriate for a DHR to be conducted without delay and the Overview Report and supporting documents should be submitted to the Coroner to help inform the Inquest.
- In cases where the suspect is arrested and charged, the commissioning of the Overview Report should be held temporarily until the conclusion of the criminal case but agencies and interested parties should be notified of the requirement and be obliged to secure any records pertaining to the homicide against loss and interference. In these circumstances, the Review Panel should ensure records are reviewed and a chronology drawn up to identify any immediate lessons to be learned (an immediate IMR). These should be brought to the attention of the relevant agency or agencies for action, secured for the subsequent Overview Report and forwarded to the disclosure Officer for the criminal case. Any identified recommendations should be taken forward without delay.
- Following the criminal proceedings the DHR should be concluded without delay.

3b **Methodology**

Once it had been decided that a Domestic Homicide Review was to be undertaken members of the Panel were sought covering as wide an experience base as possible and with partners from all key agencies. The decision was to keep the actual membership of the Panel quite small but to have a list of specialists in different fields that we could call on as and when the need arose. As this was the first DHR in Essex there were many people who felt that they should be included, however, they had no knowledge of the area, Domestic Abuse or the process that would be

involved and it was felt that a small Panel of experts would be able to achieve better results.
The Panel met regularly and decided on the courses of action to be undertaken. IMRs were sent out to all agencies who may have known this family and the Panel considered their responses. The information was analysed and the conclusions and recommendations came from this information together with an Action Plan and a Lessons Learned document which may be of use to other professionals when undertaking a DHR in the future.