DOMESTIC HOMICIDE REVIEW

REPORT INTO THE DEATH OF MK

Report produced by Broxbourne Community Safety Partnership

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1. Introduction

1.1 This report of a Domestic Homicide Review examines agency responses and support given to MK, a resident of the Borough of Broxbourne, Hertfordshire prior to her death on a date unknown but estimated to be between 7 and 11 January 2013.

1.2 The key purpose of this review is to understand what happened, what lessons have to be learned and most importantly, what has to change to reduce the risk of such tragedies in the future.

1.3 This review was commenced on 8 February 2013 and completed on 17 April 2014.

2. Confidentiality

2.1 The review has been approved by the Home Office Quality Assurance Panel, as outlined in a letter dated 21 July 2014, and included as an Appendix. The Quality Assurance Panel stated that there were some issues which would benefit from further consideration and clarification and these have now been addressed. The report has been shared, without the names of staff, with the family members of the victim who asked to be involved in the review. The Broxbourne Community Safety Partnership which commissioned the Domestic Homicide Review made a decision to publish the Executive Summary of the final report.

3. Dissemination

3.1 The following agencies have received copies of the report.

- Barnet and Chase Farm NHS Trust
- Broxbourne Borough Council
- Citizens Advice Bureau, (CAB) Broxbourne
- Crime Reduction Initiative
- Dacorum Borough Council
- Hertfordshire and South Midlands Area Team, NHS England
- Hertfordshire County Council Health and Community Services
- Hertfordshire County Council Community Safety Unit
- Hertfordshire Constabulary
- Hertfordshire Partnership University NHS Foundation Trust
- Hertfordshire Probation Trust
- Hertfordshire Public Health/Domestic Violence Strategic Board
- Safer Places
- Victim Support, Independent Domestic Violence Advocate (IDVA) Service

EXECUTIVE SUMMARY

4. The review process

4.1 This summary outlines the process undertaken by Broxbourne Domestic Homicide Review Panel in reviewing the murder of MK.

4.2 It is understood that she was murdered by her husband who then took his own life. The exact time and date of these events is unknown but is estimated to have been between 7 and 11 January 2013.

4.3 The review process began with an initial meeting, on 8 February 2013, of all agencies that potentially had contact with the couple prior to their deaths.

4.4 Agencies participating in the case review are:

- Barnet and Chase Farm NHS Trust *
- Broxbourne Borough Council*
- Citizens Advice Bureau, Broxbourne *
- Crime Reduction Initiative
- Dacorum Borough Council *
- Hertfordshire and South Midlands Area Team, NHS England *
- Hertfordshire County Council Health and Community Services
- Hertfordshire County Council Community Safety Unit
- Hertfordshire Constabulary *
- Hertfordshire Partnership University NHS Foundation Trust *
- Hertfordshire Probation Trust
- Hertfordshire Public Health/Domestic Violence Strategic Board
- Safer Places *
- Victim Support, IDVA Service *

4.5 Agencies were asked to give chronological accounts of their contact with the victim and perpetrator prior to their deaths. Where there was no involvement or insignificant involvement, agencies advised accordingly. Each agency‘s report covered the following:

- A chronology of interaction with the victim, perpetrator and/or their family; and analysis of involvement;
- whether internal procedures were followed; and
- examples of good practice, lessons learned and recommendations from the agency’s point of view.

4.6 The accounts of involvement with the victim and perpetrator cover different periods of time prior to their deaths and some of the accounts have more significance than others.

4.7 12 agencies responded of which 3, that is Crime Reduction Initiative (CRI), Hertfordshire County Council Health and Community Services and Hertfordshire Probation Trust reported as having had no contact with the victim or the perpetrator. Those which responded with information indicating some level of involvement with the victim or perpetrator are noted with an asterisk in 4.4 above.

4.8 Two solicitors, who were in contact with both of them were asked to participate in the review but declined on the basis this would be a breach of confidentiality.

4.9 The police report shows that Hertfordshire Constabulary first had contact with the victim on 13 March 2009 when she attended Cheshunt police station and reported that she was being emotionally, but not physically abused by her husband. The last contact with police was on 7 June 2012 when she reported receipt of abusive e mails from her husband regarding divorce proceedings. This was assessed as a low risk domestic related incident – non crime.

5. The purpose of the review

5.1 Domestic Homicide Reviews (DHRs) were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004) and this provision came into force on 13th April 2011. In Hertfordshire the county's Domestic Violence Strategic Programme Board oversees the DHR process and invites the community safety partnership, covering the area where the victim was last resident, to conduct a review; in this case Broxbourne.

5.2 The purpose of the review, as contained in the Terms of Reference agreed by the review panel, was to establish:

5.2.1 How effective agencies were in identifying both individual's health and social care needs and providing support;

5.2.2 The appropriateness of agency responses to both individuals - both historically and within a month of their death.

5.2.3 Whether single agency and inter-agency responses to any concerns about domestic violence were appropriate.

5.2.4 How well agencies worked together and to identify how inter-agency practice could be strengthened to improve the identification of, and safeguarding of, vulnerable adults and children where domestic violence is a feature, and to identify,

5.2.5 On the basis of the evidence available to the review, whether MK's death was predictable and preventable, with the purpose of improving policy and procedures in Hertfordshire and more widely.

5.3 The review focused on events from 1 January 2007, until the time of death.

6 Findings

6.1 The findings have been drawn from a review of each of the individual management reviews (IMR's). In addition consideration has been given to agencies' responses to the Terms of Reference. The questions outlined in key lines of enquiry, in paragraphs 1.5.1 – 1.5.4, have also been taken into account.

6.2 Some of the agencies involved in this review have policies and procedures which are specific to domestic abuse whilst others use the county council inter agency procedures for safeguarding children and vulnerable adults; and have been trained accordingly. The procedures for children are specific in respect of domestic abuse whilst those for adults are not, and are based on a definition of vulnerable adult which does not include a victim of domestic abuse; this is currently being addressed by the Safeguarding Board. Some of the agencies have recognised the need to revise their procedures and carry out additional training, and have included this in their IMR recommendations.

6.3 GP services do not have policies and procedures for domestic abuse but have access to Department of Health guidance entitled “Responding to Domestic Abuse: Guidance for General Practices” (2012); it is understood that GP’s at the surgeries where MK was a patient have not yet received training in domestic abuse.

6.4 In the period covered by this review MK disclosed to a number of agencies that she had been subject to domestic abuse by her husband. She did not give details of physical violence but referred to fleeing domestic violence and confirmed verbal and emotional abuse. She also said her husband was a bully and controlled her finances.

6.5 MK had four contacts with Broxbourne CAB between 2007 and 2011. The IMR has identified several learning points which have been addressed in their recommendations. They acknowledged that although the advice given on each of her visits to CAB was correct it could have been more comprehensive covering such resources as Women’s Aid, the Domestic Violence Helpline and formulating an escape plan. Their information system is extensive and contains an excellent item on domestic abuse but the advisers do not appear to have consulted it, suggesting awareness needs to be raised about the resource. The IMR also noted that the first two contacts were not linked together and had they been, it may have given rise to questions about whether a pattern was emerging. Also, abusive, threatening texts and refusing to provide money do not seem to have been recognised as domestic abuse, in the early interviews, another indication there is a training need.

6.6 Her husband attended Broxbourne CAB on one occasion in October 2010 when he sought advice with regard to his property assets in the light of the proposed divorce. He was advised to go to a solicitor and given a list of solicitors, an appropriate response to his presenting needs.

6.7 During the period under review, MK had five contacts with police in respect of alleged domestic abuse, the first three in 2009, one in 2010 and the fourth in 2012, which was 7 months before her death. On 13 March 2009 she reported that she had previously been physically abused but said the current abuse was emotional rather than physical and continued to maintain this in her other contacts with police. A formal risk assessment was not completed for her first three contacts with police, the first Domestic Abuse, Stalking and Harassment and Honour Based Violence risk identification (DASH) being done in October 2010 and then again in June 2012, and MK was seen as low risk on each occasion, which seems an appropriate assessment with the information she gave them. In March 2009 a significant interest (SIG) marker was placed on the home address and this was borne in mind when a 999 call was received to the address in May the same year. MK was offered assistance and advice including how she could secure molestation and restraining orders. The IMR questioned whether police should have visited her husband in October 2010 to speak to him about the allegations which MK was said to have made to a refuge worker. MK said she did not want him to be spoken to; nevertheless this course of action should have been considered and was not. The same would apply to the allegations of abusive e mails made in June 2012.

6.8 Although there is a question mark about the date, MK had one contact with Dacorum Borough Council, most likely in December 2009, when she met with a housing advice officer. The officer was able to ascertain that MK had experienced years of abuse from her husband and had left to stay with her daughter in the Dacorum area. The housing advice officer gave MK information about the Sunflower Centre and CAB, both potential sources of assistance to her. The IMR undertaken by the Council identified a number of learning points which included that:

- A risk assessment was not undertaken
- A referral or contact with a Multi-Agency Risk Assessment Conference (MARAC) was not made, to establish possible involvement by other agencies.
- Temporary accommodation was not discussed or offered.
- A homelessness application was not taken or investigated.
- Housing options regarding the marital home were not explored.
- Additional supporting information including medical was not obtained.
- No consideration was given to contacting agencies (mental health) in the area of the marital home with regard to the welfare of MK's son.
- The case was not followed up in the way the housing officer had said it would be.

6.9 Since they had contact with MK, Dacorum Borough Council report having made improvements to the service they offer victims of domestic abuse which include weekly case reviews carried out by lead officers and the appointment of a designated "champion" within the council, recognised by Co-ordinated Action Against Domestic Abuse (CAADA), who delivers training and is available to offer advice. Other improvements are sought through the recommendations included in their IMR.

6.10 Broxbourne Borough Council had just one significant contact with MK when, in October 2009, she visited the Council Housing Needs Service. Although there was no formal assessment the Homelessness Prevention Officer was able to ascertain that she was fleeing domestic abuse and she was offered assistance in line with the Council's practice at the time. In particular she was offered, but declined, a refuge in a neighbouring area. As was the case with Dacorum Borough Council, this review has caused Broxbourne Borough Council to identify several learning points and they have begun a series of improvements in policy, procedures and training arising from their IMR recommendations.

6.11 After MK's death it came to light that she had contact with a swimming instructor (employed by Broxbourne Borough Council) between March 2011 and December 2012 and although she told the instructor that her husband had treated her badly she did not refer to physical violence; and in these circumstances the instructor could not have been expected to take any action.

6.12 Her husband's only contacts with Broxbourne Borough Council during the period covered by this review were as a result of him renewing his Private Hire Vehicle Driver's Licence and following neighbour reports about noise, from his dog and chickens; and these do not seem to be of any significance to the review.

6.13 Hertfordshire IDVA Service records show that they received a referral for MK from Dacorum Borough Council in December 2009. On 4 January 2010 an IDVA saw MK and assessed her as high risk using DASH. Although this conflicts with other agencies' assessment of her as low risk, it reflects the situation she reported at the time and as it was at the lower end of the high risk category it would not have triggered a referral to MARAC. MK was offered support by a referral to a refuge and a letter was sent to Dacorum Borough Council in support of her request for re-housing. When IDVA tried to make contact with her on two further occasions, they did not get a reply and closed the case.

6.14 The IMR completed by Hertfordshire Victim Support IDVA Service highlights that the service was not as effective as it could have been in assessing MK's needs and providing support, and identifies a number of learning points which include:

6.14.1 When the risk assessment process was completed the police employed IDVA's, based at the Sunflower Centre. They were and still are, unable to directly access Victim Support's case management system (CMS), where there may be useful information to assist the IDVA to manage the case effectively, for example to inform a risk assessment and formulate a safety plan.

6.14.2 There is no record of a safety plan being completed with her.

6.14.3 Although IDVA practice is for three attempts to be made at contact before a case is closed only two were made in this case.

6.14.4 There is no document or protocol which sets out the business process that should be followed by the Hertfordshire IDVA service.

6.15 As a result of the learning points, improvements are being made to the IDVA service, which include production of a local IDVA Standard Operating Process, based on the CAADA Guidance. This and other improvements are within the recommendations included in Victim Support's IMR.

6.16 MK received a lot of support from Safer Places. As well as attending some organised sessions, like the Freedom Programme, it appears she was comfortable just dropping in there to see staff. She also had numerous appointments with a solicitor based at Safer Places, the last being in December 2012. Safer Places would have been the obvious place to go or telephone had she been concerned about domestic abuse during late December 2012, early 2013. There is no evidence she did but as described by Women's Aid, there are a number of reasons why women do not leave an abusive partner or seek assistance, which may have applied to MK at this time; this includes feeling embarrassed or ashamed, still caring for a partner, feelings of guilt about leaving and insecurity about the future. In this case there may also have been a cultural dimension due to her background being one where separation from one's spouse is not considered as acceptable or common place as it might be in this country.

6.17 MK's last one to one contact with a support worker at Safer Places was in October 2012 when she was living on her own. She was DASH assessed by a trained and experienced practitioner. She did not identify any current or recent domestic abuse and she said she was not afraid of her husband but frustrated by the delay in settling the divorce, which was seen as a form of financial abuse. She was assessed as low risk, encouraged to attend drop in sessions and to engage in programmes. MK was also encouraged to see her GP as she said she was not sleeping well. She did not present as having any mental health problems and at that time she was described as "happy, strong and looking forward to the future".

6.18 Since MK's death, staff at Safer Places learned from one of her friends that she had received abusive texts from her husband in the period before her death. They were concerned that despite all the contact she had with them and the fact she knew how to access their services, including the 24 hour helpline, she did not tell them about this. It led them to consider whether she had understood the significance of the texts in the

context of harassment, and they have picked this up as a learning point and included action within their IMR recommendations. They have also arranged for a DASH assessment to be undertaken on any client seeking legal advice so that this serves as a baseline and provides an opportunity to talk to all clients about recognising signs of increasing risk, and to encourage them to seek support in the event risk escalates.

6.19 During the period covered by the review MK was registered with three different GP surgeries. From 2007 until July 2010 most of her contact was with GP2 whose records show that she suffered considerable pain due to osteoarthritis in hands and knees. She was also depressed due to her marital situation, describing her husband as verbally and financially abusive. Although MK told GP2 he had been physically abusive in the past she said he was not at the time she was seeing the GP. MK spoke about carrying a suicide note but she did not present as a serious suicide risk. She was prescribed antidepressants but the GP said she did not always follow advice about taking the full course. The GP described having a number of "chats" with MK which included the possibility of going to a refuge, her situation when she was staying with a daughter and also when she was planning to move into a rented flat. GP2 gave MK information about Women's Aid and the Domestic Violence Helpline, and MK clearly saw the GP as a means of support because she was very upset when the GP was leaving the practice.

6.20 MK was a patient at two other GP surgeries, one from September 2010 until April 2011, the second from April 2011 until her death. She was seen on several occasions for physical matters when her psychological well-being was also discussed. Early in 2012 she was diagnosed with anxiety and depression; GP's report that at no time was domestic abuse disclosed. In October 2012 she was very depressed, prescribed antidepressants and referred for counselling. At a review later in the month she was said to be feeling calmer; medication continued on a repeat prescription but there is no evidence of this being dispensed. The Enhanced Primary Mental Health Service (EPMHS) received the referral for counselling and closed the case in November 2012 as MK did not respond to contact.

6.21 Her husband was a patient at the surgery in Waltham Cross until his death. He had several health problems that brought him back to the GP as well as requests for medical assessment to drive a private hire vehicle. There were recurring themes of stress, use of alcohol and smoking, and he was prescribed antidepressants intermittently. The possibility of cancer was indicated in 2010 but not found and he had an ongoing lower back problem which resulted in physical and psychological pain.

6.22 He presented to his GP on 27 November 2012 with what was described as a "single major depressive episode", and as a result he was prescribed anti-depressants and referred to the mental health service, EPMHS. The referral was picked up very promptly through Single Point of Access and then the Specialist Mental Health Team for Older People (SMHTOP). The decision was for ongoing contact, but this was overtaken when he became an in- patient at Lambourn Grove on 17 December 2012.

6.23 The IMR prepared by Hertfordshire and South Midlands Area Team, NHS England raised some questions about practice and identified learning points which include:-

6.23.1 Although both individuals were registered at the same surgery, where they had extensive contact until September 2010, there was no internal discussion about them except informally, and that if information had been exchanged this may have prompted different action, or a safeguarding referral for MK.

6.23.2 It is difficult to ascertain whether, when MK changed GP practice, the level of concern was shared with subsequent GP's.

6.23.3 Although GP2 took a supportive role in the holistic care of MK and made her aware of services to access, she did not discuss her situation with an outside agency.

6.23.4 There is a question about the long term care of people with multiple or complex mental health needs including unresolved grief, depression and alcohol dependency within GP practice as her husband was managed only when he presented in crisis.

6.23.5 There is also a question whether the GP's were aware of the risks regarding elderly homicide-suicide, vulnerability and spousal assault, and have understanding of how the mental health team work (in respect of scope for treatment, for example). The IMR made specific reference to research which informed a key part of the National Confidential Inquiry into Suicide and Homicide Annual Report 2013 (Healthcare Quality Improvement Partnership). This research recorded that:

- There is an increase in rates of homicides followed by suicides of older perpetrators;
- Marriage is a protective factor;
- Female spousal victims are usually younger than the perpetrators and the risk increases as the age difference between spouses increases;
- Men who commit suicide had more physical health problems; and many were receiving care from their wives;
- The perpetrator nearly always had a psychiatric condition.

6.24 The learning points raised in the IMR have been picked up in the recommendations for Hertfordshire and South Midland Area Team, NHS, which commissions GP services.

6.25 Hertfordshire Partnership University NHS Trust, which provides mental health services, had contact with both individuals as a result of the husband's acute episode of mental health care during a six week period which commenced 30 November 2012 and ended with the death of both individuals. This contact comprised:

6.25.1 Assessment by Single Point of Access followed by assessment by the Specialist Mental Health Team for Older People;

6.25.2 Admission to Lambourn Grove for assessment and treatment which lasted for five days following which he was discharged to the Crisis Assessment and Treatment Team (CATT).

6.25.3 Care and support from CATT for a period of almost three weeks.

6.26 The husband initially presented with mental health problems triggered by his difficulties in coping with his wife having left him and the subsequent divorce proceedings. The emotional and financial consequences were causing him distress and he had been abusing and self-medicating with alcohol in an attempt to cope. He was hospitalised because he presented as suicidal but during the time spent in hospital he made good progress and this seemed to be largely due to his wife having signalled that she was considering returning to him. She visited him, started wearing her wedding ring, and agreed to provide support to him on discharge from hospital.

6.27 A number of risk assessments were carried out in the course of his care. He was assessed as suicidal on his admission to Lambourn Grove but the return of his wife was judged to be a significant protective factor and he was seen as low risk of suicide whilst under the care of CATT. The Trust's IMR found this a reasonable assessment with the information available to CATT at the time, but as they did not carry out their own assessment when he was discharged to their care, there was "little exploration of what triggers might increase the risk of suicide and what risk might be posed if his wife decided not to return to him permanently".

6.28 MK was interviewed, alone, as part of the assessment undertaken when her husband was admitted to Lambourn Grove. She disclosed to the doctor, in confidence, that he had made her fear for her own safety in 2007, she went to the police but she had not wanted any action taken; she also said she had previously been in a refuge and that he had a forensic history associated with his first wife. She said that her husband had not been physically violent towards her and she gave the impression to the doctor that she was not afraid of him at that time. The doctor who conducted this assessment raised the question of safeguarding for MK, but this was not progressed as the clinical care team did not consider she met the Hertfordshire Inter Agency Safeguarding criteria for vulnerable adult, the mechanism by which the Trust and other agencies raises concerns about safety and well-being. As MK indicated she was happy for her husband to be discharged into the care of CATT with her support, the clinical care team accepted she felt safe to do this.

6.29 The IMR prepared by Hertfordshire Partnership University NHS Trust concluded that MK's disclosures about her perceptions of risk of harm from her husband in the past suggested a serious vulnerability that should have been explored further at the time and certainly prior to his discharge into her care; and that any factors that may have emerged from such a discussion could have had an impact on the risk assessment carried out on the 21st December 2012, prior to his weekend leave and subsequent discharge.

6.30 When he was discharged from Lambourn Grove, MK assumed a role as his carer and the IMR considered whether a carer's assessment would have provided an opportunity to examine, in depth, MK's situation; it concluded that this was probably unrealistic in the time frame but would have been undertaken if he had been discharged from CATT to longer term mental health services and if MK was continuing to care for him.

6.31 When CATT staff provided care for her husband they had not read the comprehensive assessment undertaken when he was in Lambourn Grove and were not, therefore, aware MK had disclosed previous concerns for her safety and that he had been verbally abusive to her in the past. During the period CATT were caring for her husband, MK expressed concerns about his behaviour. Although he began a programme of detoxification whilst in Lambourn Grove, he relapsed into drinking on his return home, which appeared to be linked to insomnia. On one occasion, in the early hours of the morning, MK telephoned CATT, sounding distressed, because he had been drinking and was harassing her to buy more alcohol; later the same day she said she found it difficult to cope because he was awake at night and sleeping during the day. Three days later she told CATT that she found alcohol he had hidden and when she threw it away he became verbally abusive to her. The IMR concluded that these events did not raise possible concerns for CATT staff about safeguarding, and that had they been aware of MK's previous disclosures about her vulnerability, they may have been more active in considering any risks that he might pose to MK. In addition the IMR concluded that the

frequent reports of insomnia and continued use of alcohol were indicators of stress to which the CATT were reactive rather than proactive; there was no care plan to manage the problem.

6.32 CATT staff had frequent contact with her husband via home visits and telephone calls. MK was usually present on the home visits and although he had a mobile and land line many of the telephone calls to him were via MK's mobile. The IMR concluded that the CATT placed an over-reliance on telephone contacts with him as a means of assessing his mental state and whether he needed a home visit. These contacts frequently resulted in MK reporting on her husband's condition or him self-reporting, rather than the CATT having face to face contact which would have been of benefit for assessment purposes.

6.33 CATT had their last contact with MK on 31 December 2012 and with her husband on 4 January 2013. There was a seven day period when they were not able to get in touch with him and even though they considered him low risk, the IMR concluded that they should have requested a welfare check by the police before they did.

6.34 The Trust's IMR reported that the overall co-ordination of care provided to the husband, particularly when he was with the CATT, was weakened by the absence of any single person focussing on his care. This and the other learning points referred to above have been included in the IMR recommendations, included in Appendix 2.

6.35 MK's last recorded contacts were a text to her daughter on 6 January and talking to a friend on 7 January and it is understood she was murdered by her husband who then took his own life, between 7 and 11 January 2013.

7 Conclusions

7.1 Between 2007 and 2010, prior to leaving her husband, MK initiated contact with several agencies when she was open about her experience of domestic abuse, which she described as verbal and emotional, not physical, and she sought advice and help linked to her disclosures. CAB, Broxbourne and Dacorum Borough Councils, the police and Safer Places all assessed her as low risk which seems appropriate given the information she provided. There was no inter agency work but each of the individual agencies offered assistance, including provision of information about other resources which could be of help to her, and this was commensurate with her perceived risk and presenting problems.

7.2 One agency, Dacorum Borough Council, made a referral to another agency, IDVA service. The IDVA assessed MK as (the lower end of) high risk to reflect the fact she had recently left her husband, this being a time when victims are known to be at high risk. After the first meeting the IDVA offered MK a further meeting to which she did not respond. In line with their procedures the IDVA service should have made an additional attempt to contact her.

7.3 MK received a lot of assistance from GP2 in the period prior to her leaving her husband which included emotional support and providing information about relevant services.

7.4 After she left her husband, MK had less contact with agencies although she visited CAB once and continued to go to Safer Places with whose staff, including solicitor, she

enjoyed a positive and supportive relationship; by then most of the contacts were due to concerns about the divorce, particularly financial matters. She continued to see her GP in connection with physical ailments and in addition she was diagnosed with depression which was linked to her concerns about the divorce; she was offered specialist counselling which she did not take up.

7.5 MK contacted the police once after she had left her husband when in 2012 she complained that he was sending her abusive texts. She wanted this on record but told the police she did not want their intervention. They should have considered speaking to TK about this but did not.

7.6 MK left TK in 2010 and initiated divorce proceedings in 2011. She renewed contact with him via their daughter in October 2012 and was present on his admission to Lambourn Grove on 17 December 2012. On TK's discharge from hospital MK agreed to support him, did not appear afraid of him and signalled that she may return to him longer term. The review concluded that MK may have felt under some obligation to agree to support her husband on his return home.

7.7 MK's contact with HPUFT mental health services in the few weeks before her death was a direct result of her husband's ill health. In light of what she said to the psychiatrist at Lambourn Grove about possible safeguarding needs and the concerns she expressed to CATT about him harassing her and being verbally abusive, there were missed opportunities to talk to her about her own vulnerability, as well as any risks she might be exposed to and whether or not she needed help.

7.8 In considering whether MK's murder was predictable or preventable the DHR panel concluded that based on the information available to the agencies at the time, that her husband was verbally and emotionally but not physically violent towards MK, it could not have been predicted that he would kill MK; and that her murder may have been preventable had she not returned to stay with him.

7.9 Both of his daughters reported that he was very concerned about the possible financial consequences of divorce. Also it was known that if MK left him his risk of suicide might increase, but there was no evidence that this had or was about to happen. However neither MK nor her husband had contact with the agencies after 4 January 2013 and there may have been a change of circumstance that precipitated the tragic events.

8 Recommendations

8.1 Each of the agencies which have produced individual management reviews for this Domestic Homicide Review have made recommendations for their agencies and, in some cases, have action plans which are already being implemented. The overall recommendations included here have drawn on those identified in the IMR's particularly the need to revise and improve procedures, including risk assessment, inter agency working and information sharing, as well as provision of additional training. Two of the recommendations arising from the comprehensive internal review, completed by Hertfordshire Partnership University NHS Trust, are included here because of their significance in respect of safeguarding adults and the needs of carers, which were highlighted as concerns for MK. The specific recommendations for the NHS GP services reflect the need for them to adopt existing national guidance on domestic abuse and be in a position to participate effectively in the DHR review process.

8.2 Staff of Lambourn Grove and SE CATT must both ensure that any assessments routinely include consideration of any safeguarding issues for the service user and significant others and that MDTs include safeguarding on their assessment checklists automatically. This must be carried through to CPA discharge planning reviews.

8.3 Staff of Lambourn Grove and SE CATT must both also ensure that the needs and vulnerability of carers are actively considered, particularly in the light of the service user experiencing an acute episode of mental illness.

8.4 In order to facilitate an understanding of how the agencies work and to make best use of resources, the agencies involved in this review should work together to ensure that they,

8.4.1 Have a robust process for identifying domestic abuse, which includes clarity about when DASH should be used and by which agencies.

8.4.2 Have information about services available to victims, which is brought together in a leaflet.

8.4.3 Provide staff with clear pathways for referring victims on to the appropriate services, and

8.4.4 Provide awareness training for staff, which is updated every three years.

8.5 Hertfordshire and South Midlands Area Team, NHS England should ensure that GP services involved in this review adopt the Department of Health Guidance on Domestic Abuse.

8.6 Hertfordshire and South Midlands Area Team, NHS England should ensure that GP's engage with the DHR process and that their records contain sufficient detail for the purpose of completing adequate individual management reviews.

8.7 The Hertfordshire Domestic Violence Strategic Programme Board should establish an information sharing protocol in cases of domestic abuse to include agencies and voluntary organisations involved in this review. The protocol should include the role and purpose and timing of referrals to MARAC and IDVA's.

8.8 The Hertfordshire Domestic Violence Strategic Programme Board should facilitate learning events to ensure the findings of this review are disseminated within agencies.

APPENDIX

Home Office

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21 July 2014

Dear Ms Taylor,

Thank you for submitting the Domestic Homicide Review (DHR) report from Hertfordshire (Broxbourne) to the Home Office Quality Assurance (QA) Panel.

The QA Panel would like to thank you for conducting this review and for providing them with the Executive Summary, Overview Report, and Action Plan. In terms of the assessment of reports the QA Panel judges them as either adequate or inadequate. It is clear that a lot of effort has gone into producing this report, and I am pleased to tell you that it has been judged as adequate by the QA Panel.

There were some issues that the QA Panel felt would benefit from further consideration and clarification before you publish the final report:

- Please review the report and consider inclusion of further text to explore the cultural dimensions in this case;

- The QA Panel felt that the text should be reviewed to ensure it is clear to the reader how the issues raised in the Individual Management Reviews (IMRs) follow through the narrative to the recommendations and the Action Plan;
- In places, the QA Panel considered that the tone and language used in the report could be misconstrued. Please review the report to ensure references could not be construed as victim blaming; and,

- Consider whether some of the conclusions drawn in this case are potentially too speculative. For example, the conclusion in paragraph 7.5.

The QA Panel noted your good work engaging the family in this review and would like to further suggest that earlier engagement with the families involved in future DHRs would be helpful to the review.

We do not need to see another version of the report, but I would ask you to include this letter as an appendix to the report when the report is published.

Yours sincerely,

Christian Papaleontiou, Acting Chair of the Home Office Quality Assurance Panel
Head of the Interpersonal Violence Team, Safeguarding & Vulnerable Peoples Unit