Domestic Homicide Review

- Executive Summary –

Commissioned by

Hammersmith & Fulham
Community Safety Partnership

Victim: "Jane"
Died: June 2016

Independent Chair and Report Author: Stephen Roberts QPM, MA (Cantab)

Date Completed: March 2019

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1. The Review Process

1.1 This summary outlines the process undertaken by a Domestic Homicide Review Panel of the Hammersmith & Fulham (H&F) Community Safety Partnership (CS) in reviewing the circumstances surrounding the death, in June 2016, of a woman resident in its area. She was killed by her partner who then died by suicide.

1.2 The following pseudonyms have been adopted for the victim and perpetrator to protect their identities:

Jane	Born: Caribbean Island	Resident of Hammersmith & Fulham	Black, Grenadian	No known religious affiliations
John	Born: Caribbean Island	Resident of Hammersmith & Fulham	Black, Grenadian	No known religious affiliations

The pseudonyms were chosen by the Independent Chair in consultation with the family member who engaged with the review.

1.3 An inquest was held in respect of the death of Jane in October 2016. HM Coroner concluded that Jane had been unlawfully killed. It was his conclusion that there had been no evidence of any "red flags" which agencies should have noticed and thus that there had been no reasonable opportunity for any intervention. HM Coroner concluded that John had taken his own life.

1.4 The Hammersmith and Fulham Community Safety Partnership commissioned this review because the circumstances of the homicide fell within the terms of Section 9 of the Domestic Violence, Crime and Victims Act 2004. The review was formally commissioned on 17th August 2016. All agencies (see below) were asked to secure whatever material they might have to contribute to the review and, where appropriate, commence their own Individual Management Reviews (IMR).

1.5 Completion of the review was considerably delayed beyond the six-month limit specified in the guidelines. These delays were the result of particular factors:

- The time taken to negotiate and arrange discussions with family members and friends, some of whom lived abroad. Seeking family views on the draft report entailed considerable additional delay.
- Delays in access to medical records, eventually resolved by NHS England. It should be noted that the delays were the result of the relevant Practice

Manager (who was unaware of current guidance) exercising proper caution in disclosing medical records.

- Identifying appropriate community-based groups with which to discuss the needs of BME women relevant to this review.
- Additional IMRs were required at a late stage of the review.
- The need for additional Review Panel meetings
- Achieving the agreement of the Review Panel on the content and language of the report.
- Immediately prior to the presentation of the review reports to the CSP, senior CSC staff re-examined case records and discovered additional information which had not been provided to the review at an earlier stage. The discovery necessitated amendments to the report to ensure its accuracy and completeness.

1.6 The Independent Review Panel gave final approval of the Overview Report and Executive Summary via email in March 2019. The Overview and Executive Summary reports were taken to the Community Safety Partnership on 7th June 2019 and formally agreed in September 2019 following a request for amendments by the CSP. The Home Office was updated as to this fact on 11th August 2019. Following the completion of agreed changes, the DHR was submitted to the Home Office Quality Assurance Panel for review and approval on 27th September 2019.

2. Contributors to the Review

2.1 IMRs were requested from:

- the Family GP Practice (which had provided care for both parties)
- H&F Children's Services
- H&F Housing Department

The IMRs were of a suitable quality and content and were not completed by anyone directly involved with the case. In addition to the above, formal submissions, in lieu of an IMR were provided by:

- Standing Together (DA charity)
- The Clinical Commissioning Group
- Pinnacle Trust (borough housing provider; part of H&F)

All three organisations provided helpful material which is reflected in the review and ultimately in the recommendations.

2.2 In addition to the above, the following material was made available:

- The MPS provided a copy of the report prepared for HM Coroner, detailing the immediate context of the incident and what could be discovered of the events within the home leading up to the deaths.
- The MPS also provided information on allegations of crime made by one of Jane's children.
- Access was granted to the records of H&F Children's Social Care.
- With the assistance of NHS England, access was given to the GP and hospital records of both John and Jane.
- Housing records for the address occupied by Jane and John were made available by H&F Housing Dept/Pinnacle.
- The review also benefits from information from friends/colleagues of both Jane and John, interviewed after the tragedy.

2.3 In addition to the material referred to above, the Violence Against Women and Girls (VAWG) Strategy 2015 to 2018 was examined together with the 2015/16 and 2017/18 VAWG Annual Reports. The 2018/19 VAWG Action Plan was also assessed.

2.4 In order to assess the accessibility of advice to members of the public, the relevant H&F websites were examined. Additionally, a dip sampling exercise was conducted by the Independent Chair. The exercise was undertaken on a weekday evening between 5.00 pm and 7.30 pm. Each medical centre/GP practice, pharmacy and local supermarket in the vicinity of Jane's flat was visited to search for any publicly available written material offering advice and/or contact details for DA services. At each medical centre, notice boards were examined for such advice and the reception staff on duty spoken to.

2.5 Jane was the mother of three adult children (A, B and C)[1], one of whom lived at the address where the tragedy took place. The Independent Chair met two of the three children and members of the extended family at Jane's inquest. He explained the nature of a Domestic Homicide Review and his role. At the time of the inquest, family members were understandably too distressed to engage further with the review. In the weeks following the inquest, the Independent Chair wrote to the family members via their MPS Family Liaison Officer (enclosing the Home Office DHR leaflet), explaining the nature of the review and seeking agreement to make contact. This and several subsequent requests were unsuccessful. A year later, one of the children unexpectedly contacted the Independent Chair by text message and agreed to meet to discuss the relationship between Jane and John and explain something of the history of the family. Without the assistance of this family member, a meaningful review would have been almost impossible.

3. The Review Panel Members

3.1 In addition to the Independent Chair, the Review Panel members were:

Name	Job Title	Agency
Sally Jackson	Partnership Manager	Standing Together Against Domestic Violence
Felicity Charles[2]	Victims' Programme Coordinator	H&F, Community Safety
Caroline Birkett	Head of London Services	Victim Support
Guy Sanderson	Head of Service	H&F, Pinnacle Trust
Lorren Stainton	Safeguarding Programme Officer	NHS England
Janice Cawley	Detective Inspector	Metropolitan Police, Specialist Crime Review Group
Anna Carpenter	Head of Safeguarding, Review and Quality Assurance	H&F, Children's Social Care
Pragna Patel	Director	Southall Black Sisters

[1] In relation to Jane's children, the Independent Chair and Review Panel felt the anonymity of the children would be best served by the use of initials in this instance. This was deemed necessary given the allegation and disclosure of sexual abuse

[2] Came into post in 2017, previously the H&F CSU was represented by Kate Delaney.

3.2 Representatives from Hammersmith and Fulham Council's Anti-Social Behaviour Unit and Adult Safeguarding teams attended the first panel meeting but were not required as part of the substantive panel.

3.3 The Violence Against Women and Girls (VAWG) Strategic Lead, also attended one panel meeting and provided comment on the report.

3.4 The Review Panel met on 6th October 2016, 7th November 2017, 4th September 2018, 6th December 2018 and gave final approval via email in March 2019. Between October and 2016 and November 2017, the Independent Chair met with agencies independently and correspondence occurred by phone, in-person and via email with agencies. This occurred individually and collectively with partners. Based on the information ascertained during this period, the Independent Chair drafted the overview report. Following a change in Council staff overseeing the delivery of the review in October 2017, a request was made to the Chair for additional panel meetings to be convened to discuss the review collectively as a panel. As a consequence, there were three further panel meetings.

3.5 Southall Black Sisters (SBS) was identified as an appropriate specialist BME VAWG organisation to assist in the review. SBS is a voluntary-sector organisation which campaigns on (inter alia) domestic abuse issues and especially in relation to women from black and minority ethnic (BME) communities. The draft Overview Report formed the basis of detailed discussions with SBS. These discussions have informed the review and provided a wider perspective on the particular needs and barriers facing BME women experiencing domestic abuse. A representative of SBS was invited to join the Review Panel.

3.6 Both the Clinical Commissioning Group (CCG) and the GP Practice with which Jane and John were registered, were contacted at the start of this review. The CCG had no record of contact with either Jane or John and declined membership of the Review Panel – it should be noted that throughout the process, the CCG were consulted and in fact made significant contributions to the review and its recommendations. The GP Practice was unable to provide representation on the Review Panel due to a shortage of doctors and the imminent retirement of one of its senior practitioners.

3.7 Representatives from H&F's Anti-Social Behaviour Unit and Adult Safeguarding teams attended the first panel meeting but were not required as part of the substantive panel. The Violence Against Women and Girls (VAWG) Strategic Lead, also attended one panel meeting and provided comment on the report.

3.8 The Review panel agreed that the focus period for the review should be between September 2006 and Jane's homicide in June 2016. The start date enabled the allegation of sexual assault of one of Jane's children by John to be considered within the review, since this is regarded as a significant event in the course of the tragedy. Events outside this timeframe have been included in the review to provide an appropriate context.

3.9 The Review Panel met on 6th October 2016, 7th November 2017, 4th September 2018, 6th December 2018 and gave final approval via email in March 2019. Between October and 2016 and November 2017, the Independent Chair met with agencies independently and correspondence occurred by phone, in-person and via email with agencies. A request was made to the Chair for additional panel meetings to be convened to discuss the review collectively as a panel. As a consequence, there were three further panel meetings.

4. Independent Chair & Report Author

4.1 Stephen Roberts, QPM, MA (Cantab), was appointed by the Hammersmith & Fulham Community Safety Partnership as Independent Chair of the Review Panel and Report Author. He is a former Deputy Assistant Commissioner of the Metropolitan Police (retired 2009), now working as a private consultant. He has extensive experience of partnership working at borough and pan-London level. He is a former Director of Professional Standards and Director of Training and Development for the Metropolitan Police. He is entirely independent of Community Safety Partnership and all other agencies involved in this review. He has completed training for the role (including an update for the 2016 Guidance) and has successfully chaired and authored domestic homicide reviews for other Community Safety Partnerships.

5. Terms of Reference for the Review

5.1 The review was guided by the following terms of reference:

- To establish what lessons may be learned from the case regarding ways in which local professionals and agencies worked individually and collectively to safeguard victims.
- To determine how those lessons may be acted upon.

- To examine and where possible make recommendations to improve risk management mechanisms within and between all relevant agencies.
- To identify what may be expected to change and within what timescales.
- To assess whether the relevant agencies have appropriate and sufficiently robust procedures and protocols in place and the extent to which they are understood and adhered to by their staff, including an examination of the metrics and management information mechanisms in relation to risk assessment and management.
- To improve service responses including, where necessary, changes to policies, procedures and protocols.
- To enhance the overall effectiveness of efforts to reduce domestic abuse and its impact on victims through improved inter and intra agency working.
- To maximise opportunities for fast time learning and overall partnership improvements as well as medium and longer-term enhancements.

6. Summary Case History

6.1 Jane and John were born on the same Caribbean island and spent their early lives there. It is reported that John was known to have perpetrated domestic abuse against a previous partner. Jane knew John initially as a family friend, but they later formed a relationship.

6.2 John left the island to work in the United States of America. It was from the USA that he came to live in the UK, entering in 1998 and being granted indefinite leave to remain in 2012.

6.3 Jane, arrived in the UK in 1996, and was well established with her three children by the time John came to settle here. They were married in 2007, at which time, John moved into the flat occupied by Jane.

6.4 Jane had three children (Child A, Child B and Child C) by a previous relationship, all of whom were adults by the time of the tragedy. Jane is described by one of her children as, “A loving person who held the family together. It was always family first and she always looked after her kids.” The culture of the extended family is described as “very private.” Apparently, several members of that

extended family, some of whom had also settled in the UK, were aware that John physically abused Jane over a number of years. One family member recalls, in about 2000, witnessing shouting between the couple and the fact that John had hit Jane in the face. According to this account, it was only Jane's intervention that prevented this witness from stabbing John.

6.5 John dissuaded Jane from accepting lucrative job offers abroad. The fact that he sought to limit Jane's employment opportunities may be regarded as evidence of some degree of financial and coercive control.

6.6 In 2010 an allegation was made that John had assaulted Child C four years earlier. The matter was investigated by local police as well as H&F Children's Services. Child C temporarily moved out of the family home and stayed with a family member. The historic nature of the alleged offence precluded forensic opportunities and the victim ultimately decided not to be interviewed by police. Children's Services further considered the allegations as part of a section 47[3] Children's Act and conducted a Core Assessment. Jane was seen and spoken to by the social worker several times as part of the assessment. John was invited to attend the Children's Services offices for interview but declined. Ultimately, however, the social worker concluded that the family had acted protectively by reporting the allegations and agreeing that Child C should stay with another family member. There had also been suggestions from one of Jane's adult children that John had been violent toward them in the past. During the 6 – 8 week period of the investigation and assessment, Jane made no allegations of any domestic abuse by John.

6.7 Five days later a CSC Social Worker visited Child A's home and interviewed Child C, who disclosed that they had been sexually assaulted up to ten times by John as a child.

6.8 Child C ultimately decided not to be interviewed by police. CSC further considered the allegations as part of an investigation under Section 47 of the Children Act 1989 and conducted a Core Assessment. Jane was seen and spoken to by the social worker several times as part of the assessment. John declined participation. Ultimately, the social worker concluded that the family had acted protectively by reporting the allegations. During the investigation and assessment, Jane made no allegations of any domestic abuse by John. There is

[3] Children Act 1989

no evidence on the file to determine if Jane was asked directly about domestic abuse or the nature and dynamics of her relationship with John.

6.9 In September 2012 Child C presented to H&F as homeless. Child C left the office before a social worker could undertake any assessment. Jane was immediately contacted by the Duty Social Worker and told what had happened.

6.10 By 2015 the relationship between Jane and John had deteriorated. John was spending weeks at a time away from the family home and Jane had decided that the couple should separate. By April 2016 Jane had become more certain that she would seek a divorce and by early June (at the latest) she had told her children and confided in a colleague about her plans. John was aware that Jane was seeking separation/divorce.

6.11 By mid-June 2016, Jane had told John that she wished him to leave their flat permanently. Jane engaged a locksmith to change the door locks the following morning.

6.12 The following morning, Jane's resident child heard shouting and screaming from Jane's bedroom. John had repeatedly stabbed Jane and then turned the knife on himself. Police were called and arrived at about 0430 to find Jane and John both dead.

6.13 Toxicological evidence indicates that neither Jane nor John had recently consumed alcohol. John was a user of cannabis and cocaine but there is no evidence that he considered his drug use as problematic.

6.14 Jane's and John's medical records were examined. There is no indication in Jane's record of any domestic abuse enquiry or disclosure. Jane's medical record does, however, contain an unusually high number of clinical entries (1,450) and a large volume of correspondence. Jane presented to her GP Practice often and with multiple symptoms. Her medical history included multiple panic attacks, counselling referrals and a number of unplanned pregnancies couple with low mood; factors which have been highlighted in research as potential indicators of domestic abuse. Jane's medical record does not contain any note about whether she was asked specifically if she was experiencing domestic abuse. In a consultation in October 2013, a GP questioned Jane about possible causes for her multiple attendances and variety of symptoms. She apparently responded that she was "happily married with a full-time office job". There is no evidence of Jane making use of local psychology or counselling services.

6.15 The doctors at Jane's GP Practice had received training since 2010 in matters of domestic abuse as well as a briefing in the IRIS system in 2013/14 – however IRIS is not implemented locally. Of all the GP services visited in the sampling exercise of this review, only Jane's practice displayed an informative poster about where victims of abuse could seek help.

6.16 John's medical records contain no suggestion that he might have been considered as a risk to his partner.

7. Key Issues Arising from the Review

7.1 A detailed analysis of the full case history reveals various factors indicating a raised risk of domestic abuse within the family:

- evidence of some degree of coercive control and economic abuse in the relationship between Jane and John;
- allegations of John's physical violence towards Jane and her children;
- allegations of sexual abuse by John towards one of Jane's children;
- Jane's multiple attendances at her GP Practice including unplanned pregnancies, low mood, unexplained injuries;
- imminent separation pending Jane's formal application for divorce.

7.2 Research evidence, supported by the extensive experience from charities which support victims of domestic abuse, highlight that BME women face additional barriers to accessing support and note that their experience of violence and abuse is often intersecting and overlapping. BME victims of domestic abuse experience greater barriers to disclosing their situations and seeking help due to institutional racism, mistrust of social support agencies (especially the Police) which results in services being regarded as less accessible to minority groups. Specific efforts are therefore required to increase identification of BME victims and families and ensure the availability of specialist services.

7.3 The fact that domestic abuse was not identified or disclosed highlights that agencies must be alert to the many barriers which inhibit recognition and/or disclosure of abusive behaviour and work to improve access to support.

7.4 In view of the barriers to identification of abuse and access to support faced by BME women, it is vital that all agencies in contact with potential victims take every opportunity to encourage disclosure. Such efforts should include directly enquiring about abuse, particularly where indicators are present, as well as making suitable informative material available in both written and digital form.

7.5 The investigation of intra-family violence, coercive control and sexual abuse also present important opportunities to identify domestic abuse and provide critical access to support for victims. Social workers undertaking such duties require a thorough understanding of the research and evidence on these issues and of the need to ensure that full information is shared with other agencies (especially police) when considering the most appropriate ways to protect children and vulnerable adults.

7.6 The London Child Protection Procedures acknowledge research linking child abuse with domestic abuse between partners – i.e. that a significant proportion of families in which there is abuse of children, domestic abuse is also a feature. Therefore, a legitimate opportunity existed for the social workers dealing Jane's child's case to be professionally curious about the relationship between Jane and John.

7.7 In addition to the barriers to disclosure mentioned above, organisations must be alive to risk related to digital disadvantage and the challenges faced by victims who may not be able access information about DA support at home. Agencies must not, therefore place excessive reliance on websites as a primary route by which victims can find advice and/or seek support.

7.8 Jane and John lived in accommodation provided by H&F. The Housing Department provides maintenance and repair services for such flats. Although Jane arranged for her locks to be changed by a private locksmith, H&F processes highlighted that they should have been undertaken by the Housing Department. Lock changing as well as the need for repairs to what might be non-accidental damage may be indicators of unreported abuse. Maintenance staff should thus be reminded of their ability to provide early warning of domestic tensions.

8. Conclusions

8.1 Although there were no direct disclosures of domestic abuse by Jane or any family member, the review has highlighted a number of opportunities for agencies to enquire about the possibility of DA. The review acknowledges the additional barriers faced by BME victims in disclosing abuse and accessing support and identifies a clear imperative to address such barriers and the need for an intersectional approach.

9. Lessons to be learned

9.1 The barriers to disclosure and support experienced by BME victims mean that increasing identification and access to support requires services which proactively reach out to 'minority' communities. Engaging specialist BME and VAWG organisations may assist in mapping services to needs. On a cautionary note, care will be required to ensure that only organisations which work specifically with BME women facing violence and abuse should be targeted as potential partners.

9.2 The principal lessons to be learnt from this case may conveniently be grouped under three main headings:

- Barriers likely to be experienced by BME victims of abuse which may make it more difficult to access support.
- The complex and intersecting nature of these barriers and the impact they have on how violence and abuse is experienced and understood, how and where support can be accessed, and the way in which support is received and perceived. This includes the intersection between gender and race, but also considering factors such as *digital disadvantage (i.e. lack of discreet access to the internet)*.
- Missed opportunities to enquire about domestic abuse and the necessity, in view of the above factors and in the presence of indicators of DA, to ensure that professionals from all agencies are trained, proactive and able to take advantage of all opportunities to ask about, identify, and respond effectively to, abuse.

9.3 **Barriers to support** – Improving access to support for BME women requires a variety of measures both to widen awareness amongst community members,

businesses and agency professionals and to enhance facilities and specialist support. Recommendations 1, 2, 3, 5, 8(a to d) and 10 are aimed at increasing awareness amongst key groups. Recommendations 4, 6, 9 and 11 are aimed at enhancing facilities.

9.4 **Intersectionality** – An intersectional approach is critical to understanding the various ways in which race and gender interact to shape the multiple dimensions of Black women's experience. Recommendations 1, 3, and 4 further support the particular measures to increase the likelihood that BAME victims will have available to them "an environment of responsive services providing a coordinated community response". Recommendation 7 is intended to ensure that there is not an over-reliance on internet-based information which may not be easily available to BAME victims, especially those for whom English is not their first language.

9.5 **Proactive Professionals** – Professionals must make identifying domestic abuse part of what they do day-to-day. Reducing the time that it takes to identify and support victims is critical to preventing "murder, serious injury and enduring harm"[4]. Each professional contact represents an opportunity to support a victim and their family to get help. Missed opportunities to identify and respond to abuse were identified in this case and, in general, SafeLives[5] data shows that 85% of victims sought help five times on average from professionals in the year before they got effective help to stop the abuse. Recommendations 3, 8 and 10 are aimed at encouraging and supporting professionals and community members to improve identification and response to domestic abuse, recognising the difficult and sensitive challenges of safely and empathetically asking potential victims about abuse and support.

9.6 The current VAWG Strategy encompasses a range of initiatives to reduce barriers to disclosure, increase community awareness of the issues and provide support for victims. This review has identified additional opportunities to further enhance provision by the implementation of the recommendations set out below.

[4] SafeLives (2015) 'Getting it Right the First Time' https://safelives.org.uk/policy-evidence/getting-it-right-first-time
[5] ibid

10. Recommendations

Recommendation 1

In order to increase identification and access to support, material that is designed for communities where there are barriers to disclosing abuse and seeking help is required. Engagement with appropriate minority community groups could facilitate both production and dissemination of such material. The material produced should be made available to all GP practices, medical centres and other venues where it may be accessible to victims.

Recommendation 2

Workplaces offer an additional context in which disclosure of abuse can be promoted. To this end, H&F to consider a campaign to encourages workplaces and employers to raise the awareness, especially amongst managers, of domestic abuse and what may be done to support employees. – *A number of public sector examples of such an approach already exist, notably, that introduced by the London Borough of Hackney for the care of its own staff.*

Recommendation 3

Improved, evidence-based training is required to enable social services, medical and community workers to understand the particular needs of ethnic minority women in the context of domestic abuse/VAWG.

Recommendation 4

When recommissioning VAWG services, H&F should consider and promote the specialist services which may be required to cater for the needs of ethnic minority victims.

Implementation may be assisted with the advice and expertise of a suitable second tier specialist organisation e.g. Imkaan

Recommendation 5

NHS(E) via Medical Directors, to remind GP practices of the importance of all staff being aware of DA issues and indicators as well as the appropriate referral routes for those seeking advice.

Recommendation 6

Pursue current bids for funding to enable the Identification & Referral System to Improve Safety (IRIS) training for GPs and staff.

In the absence of IRIS, training on the indicators of abuse, safe enquiry and how to respond to DA to be delivered to GP practices in the borough.

Recommendation 7

Examine the currently available material to ensure that there is not undue reliance on internet-based advice to ensure adequate advice is available to those who lack access to internet services.

Recommendation 8a

H&F Children's Services manager and social workers to consider the research around links between sexual abuse, homelessness and domestic abuse during contacts with families.

Recommendation 8b

H&F social workers to explore parental relationships and make routine enquiries about domestic abuse when children make allegations of sexual abuse and/or physical abuse about parents.

Recommendation 8c

H&F Children's Services manager to ensure that dates of birth and full police checks are completed and recorded and considered as part of s 47 core assessments.

Recommendation 8d

H&F provide updated training to front line social workers on linking sexual abuse to domestic abuse.

Recommendation 9

VAWG providers to consider opportunities to offer specific targeted services to identified ethnic minority groups to improve disclosures of abuse and thus access to DA services.

Recommendation 10

Raise the awareness of DA amongst Housing staff and contractors of the opportunities which may be presented to identify unreported abuse.

Recommendation 11

The Home Office to support NHS(England) in commissioning IRIS nationally, thereby promoting the aims of the national "Ending Violence Against Women & Girls Strategy 2016 – 2020 (HM Government 2016).

Stephen Roberts QPM, MA(Cantab)
Independent Chair & Report Author