A Warwickshire Community Safety Partnership

EXECUTIVE SUMMARY

DOMESTIC HOMICIDE REVIEW

Under s9 of the Domestic Violence Crime and Victims Act 2004

In respect of the death of 'Richard' in May 2015

Report produced by Independent Chair
Dr Jane Monckton Smith

May 2018

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Glossary

DHR	Domestic Homicide Review
CSP	Community Safety Partnership
MARAC	Multi-Agency Risk Assessment Conference
MAPPA	Multi-Agency Public Protection Arrangements
IDVA	Independent Domestic Violence Adviser
SCR	Serious Case Review
MHI	Mental Health Investigation
VCS	Voluntary and Community Sector
SIO	Senior Investigating Officer
FLO	Family Liaison Officer
IMR	Individual Management Reviews
DASH(RIC)	Domestic Abuse, Stalking and Harassment and Honour Based Violence Risk Identification Checklist
TOR	Terms of Reference
SHA	Strategic Health Authorities
CPS	Crown Prosecution Service
SMART	Specific, Measurable, Achievable, Realistic and Timely
DVPP	Domestic Violence Perpetrator Programme
GMPS	Government Protective Marking Scheme
FOIA	Freedom of Information Act
BME	Black and Minority Ethnic
AAFDA	Advocacy After Fatal Domestic Abuse

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1. The Review Process

1.1 A decision to hold a Domestic Homicide Review (DHR) was taken by the South Warwickshire Community Safety Partnership in July 2015.

1.2 The Independent Chair was appointed in November 2015.

1.3 The initial meeting of the DHR Panel took place on the 23rd November 2015 and the final meeting of the Panel took place on 26th July 2017.

1.4. Richard (aged 55) had been in a relationship with Hannah for 4 years, since 2011. He moved in with Hannah at an address in a small Warwickshire town, a very short amount of time after meeting her.

1.5 Adam was aged 17 and was living with his mother when Richard moved in.

1.6 There was significant delay to the DHR caused by the criminal trial and in gathering information and making arrangements to meet with the family of the deceased and with the mother of Adam, who was also the partner of the deceased.

1.7 The Chair had two meetings, one in 2017 and one in 2018, with one of Richard's sisters at a location away from their home; other family members declined the invitation. The family of the deceased found the whole situation very difficult to deal with, and some family members were not at peace with Adam being found not guilty of the murder of Richard. They withdrew from the Review.

1.8 Adam was written to twice but declined to participate.

1.9 Initially Hannah declined to participate but with the support of the Family Liaison Officer eventually decided that she would like to meet with the Chair. A meeting was arranged for February 2017 but had to be re-scheduled to April 2017 due to Hannah's work commitments. The Chair met with Hannah a second time in April 2018. Both meetings took place at Hannah's home.

1.10 Information about the Charity Advocacy After Fatal Domestic Abuse (AAFDA) was given to the families but they were not involved with supporting any family member.

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2. Contributors to the Review

- Warwickshire Police,
- Warwickshire County Council, Children's Services,
- Warwick District Council Housing and Property Services,
- A Warwickshire NHS Foundation Trust,
- West Midlands Ambulance Service,
- Warwickshire MARAC,
- Stonham – Domestic Abuse Service.
- GP for Hannah, Richard and Adam
- Warwickshire County Council, Adult Social Care
- Warwick District Citizens advice
- University Hospital Coventry and Warwick
- Victim support

3. The Review Panel Members

Dr Jane Monckton Smith	Independent Chair
Kirstin Clarke	Operations Manager, WCC Adult Social Care
Sue Ingram	VAWG Strategy Development Manager, WCC
Pete Cutts	Safer Communities Manager, Warwick District Council
Jenny Butlin-Moran	Service Manager, WCC Children's Services
Claire Cooper	Senior Operations Manager, Refuge
Kirstin Lord	Locality Manager, The Recovery Partnership
Chris Evans	Safeguarding Children and Adults, Coventry & Warwickshire NHS Trust
Steve Tonks	Detective Chief Inspector, West Mercia Police
Tracy Redgate	Lead Nurse Safeguarding Adults, S. Warwickshire CCG
Stavroula Sidiropoulou	Domestic Homicide Review Officer, WCC
Holly Collins	Domestic Homicide Review Officer, WCC
Susan Haile	Personal assistant to Dr Monckton Smith

All members of the Panel had not worked directly with either the victim, perpetrator, or their families.

4. Author of the Overview Report

4.1 Dr Jane Monckton Smith was appointed by the South Warwickshire Community Safety Partnership as Independent Chair and Author of the Overview Report in November 2015. She is a Forensic Criminologist specialising in domestic

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homicide. She lectures in criminology and criminal investigation and is an active researcher and is published in the area of domestic homicide. Dr Monckton Smith trains professionals in Advanced Risk and Threat Assessment in the area of Coercive Control, Stalking and Domestic Abuse, and also works with a number of Homicide and Stalking Charities helping victims and professionals understand Domestic Homicide, and Domestic Abuse and Stalking.
Dr Monckton Smith has had no previous involvement with the South Warwickshire Community Safety Partnership nor any of the agencies involved in the Domestic Homicide Review into the death of Richard.

5. Terms of Reference

5.1 To produce a Chronology of events and actions leading up to, and in relation to, the death of Richard, from the period from 1st January 2010 until Spring 2015 including his relationship with Adam's mother, Hannah, and Adam himself.

Seeking information from:

- Organisations who had contact with them
- Local Community organisations
- Their family and friends

5.2 To review current roles, responsibilities, policies and practices in relation to victims of domestic abuse – to build up a picture of what should have happened,

5.3 To review this against actual events to draw out the strengths and weaknesses,

5.4 To review national best practice in respect of protecting adults from domestic abuse,

5.5 To draw out conclusions about how organisations and partnerships can improve their working in the future to support victims of domestic abuse.

The Review will also specifically consider:

5.6 An assessment of whether any agencies, family and/or friends were aware of any abusive or concerning behaviour from Adam to the victim (or other persons),

5.7 A review of any barriers experienced by the families in reporting any abuse or concerns, including whether they or anyone else involved knew how to report domestic abuse had they wanted or felt able to,

5.8 A review of any previous concerning conduct or a history of abusive behaviour from Adam (the person who caused Richard's death, in self-defence) and Richard, the victim, and whether this was known to any agencies,

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5.9 A review of any Multi-Agency Risk Assessment Conference (MARAC) involvement,

5.10 An evaluation of any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and/or services in Warwickshire,

5.11 Whether Richard and Adam had any previous history of abusive behaviour towards each other or anyone else, and whether this was known to any agencies,

5.12 Whether family and friends want to participate in the Review. If so, find out if they were aware of any abusive behaviour by Richard or Adam prior to the homicide,

5.13 Communication to the public and non-specialist services about available specialist services related to domestic abuse or violence,

5.14 Whether the work undertaken by the services in this case is consistent with its own professional standards and compliant with its own protocols, guidelines, policies and procedures,

5.15 The impact of domestic abuse on children and young people,

5.16 Any other information that becomes relevant during the conduct of the Review.

6. Summary Chronology and Key Issues arising from the Review

6.1 Richard (aged 55) had been in a relationship with Hannah for 4 years. He moved in with her at an address in a small Warwickshire town, a very short amount of time after meeting her.

6.2 Adam and his sister were both living with Hannah when Richard moved in. Adam was 17 at the time.

6.3 In 2013, there was an incident when Adam discovered Richard hitting Hannah; Richard destroyed all of Adam's belongings in his room following this incident. Despite this Adam remained on good terms with Richard largely to stay in contact with his mother.

6.4 Richard had been living abroad and had a partner (who he was with for some twenty years) and children still living there. Records show there had been a protective order in that country to stop Richard contacting his wife and children. He also had a criminal history including violence and robbery.

6.5 Hannah stated their relationship was plagued with violence and aggression from Richard, from the beginning. She said that Richard had a very quick and

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violent temper and was hyper-sensitive to any criticism, challenge or perceived slight.

6.6 Hannah stated that Richard could change from being very happy and personable to violent and frightening, very quickly.

6.7 His family say they never saw this side of him and he was always a happy and nice person in family gatherings and events.

6.8 Richard and Hannah were known to Warwickshire Police for eight incidents of domestic abuse, three of which were identified as high risk and discussed at MARAC.

6.9 In Spring 2015, Richard, Hannah, Adam and Adam's girlfriend, had been out for a meal and drinks. They returned to Hannah's address to continue socialising and Richard and Adam were both drinking.

6.10 During the evening an altercation took place between Richard and Adam where Richard grabbed Adam and punched him in the face and put his hands around his throat and squeezed. Hannah intervened and pulled Richard away.

6.11 Adam ran into the back garden of the property through the kitchen, where he grabbed a knife from the draining board. He went through the back gate but heard his girlfriend cry out so rushed back into the house. A scuffle ensued and Adam used the knife to stab Richard in the chest.

6.12 An ambulance was called but Richard's condition rapidly deteriorated and he died from his injuries.

6.13 Adam was charged with murder and a trial took place in 2016. Adam was found not guilty at trial by reason of self-defence. As such, Adam will be referred to as the person who caused Richard's death, in self-defence.

6.14 The analysis of the Review used the Chronology and decisions made, and the findings from the IMRs. There were four key areas for analysis: first, whether the decisions made in responding to Richard's violence fully considered the risk posed to Adam; second, what was known about the history of Richard and his violent behaviour and how that information was shared; third, the repeat violence exhibited by Richard and decisions made in respect of that; fourth, the management of high risk services, in particular MARAC.

6.15. Adam as a victim of domestic abuse

6.16 Very early on, Adam made it clear to agencies that he needed alternative housing after Richard moved in with his mother. The decision made by Warwick District Council's Housing Services (supported by a Children's Services assessment) that Adam could continue to live with his mother and Richard may have been better informed with fuller intelligence gathering, underpinned by

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professional curiosity. The information about Richard's past was available from the police, and information was available from Adam.

6.17 The effects of the decision that Adam was not homeless in 2011, was compounded with every subsequent interaction, and referral to Children's Services. It appears that decisions were based on that initial assessment only. No further assessment was done when new information related to domestic abuse and violence was disclosed.

6.18 Adam's sister also declared herself homeless around the same time and it is not known whether those two events would ever have been considered together. But they do support the idea that there was a problem within the home for these young people related specifically to Richard.

6.19 Communication from Children's Services was with Hannah, offering her advice and support. There was no re-assessment even when Adam's father contacted the service to say his son was homeless, and when police made referrals.

6.20 DASH risk assessments completed on 12 and 26 November 2011 were done with Hannah, an assessment was not done with Adam. He was just 17 at the beginning of agency involvement. A Risk Assessment could consider others subjected to violence, especially now that the official definition for domestic abuse covers anyone over the age of 16.

6.21 After 2013, as a person over the age of 16, Adam could have accessed the support of Stonham specialist DA services, however, he was never referred, neither was he risk assessed in his own right.

6.22 In this case, as Hannah was the only member of the family risk assessed, the offer of support services was only directed towards her. At the time Hannah was not in a place of recognition to accept the support and it had been declined. As Adam was not risk assessed as an individual, the support services did not offer direct support to Adam. Hannah's agreement that Adam could continue to live at home resulted in the Local Housing Authority deeming him not to be homeless. In turn, support offers which otherwise could have been available to Adam (even without further investigation into his safety through a risk assessment) were not made available to him.

6.23 Hannah was certainly dependent on the relationship to a degree and was also controlled. She was a high-risk victim of violence but did not feel, or recognise, at that time that she wanted agency support or may have felt she was unable to accept the support. Adam did want support particularly from the Local Housing Authority and this may be a gap in domestic abuse services.

6.24 Witnessing domestic abuse as a child carries its own risks. Adam may have felt that he should intervene to protect his mother, even though it had repercussions for him and his future. Adam had been assaulted by Richard previously.

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6.25 From this it could be suggested that in assessing risk, and homeless enquiries, that more questions should be asked to satisfy the assessor of the spectrum of risk. This is especially important if an initial assessment will inform future decisions. In housing applications, merely asking the question may not reveal the truth. A young person complaining of the presence and behaviour of a named adult should prompt background checks.

6.26 In a (DASH) Risk Assessment where more than one person is being assaulted, risk assessments should consider what the risk is to each person. In this case Adam was known to be a focus for violence, and he was known to be protecting his mother. His youth and victimisation could have made him subject of a Risk Assessment, and the help that might have provided for him to seek alternative accommodation when he was 18 could have been forthcoming. Local Housing Authorities should give priority need to persons who are homeless as a result of being a victim of domestic abuse.

6.27 History

6.28 In 2011, there were four Police calls to Hannah's home across five weekends. A background check at the first call could have prompted the Police to inform Hannah that she had the right to request a Clare's Law disclosure and specific advice could have been given to Hannah and Adam right at the beginning. The history could have been passed to Children's Services in the referral.

6.30 Richard's recent and past history could also have been considered when Richard was arrested after a violent incident towards Adam at his place of work in 2013. Richard was transported by Police back to Hannah's home where she was known to be a high-risk victim of Richard's violence. He almost immediately assaulted Hannah on his return to the home. The decision, whether or not, to take him back there could have been informed by Richard's history and the known violent incidents occurring at that property. Training for custody staff should include detail around not making decisions based on 'he's okay now'.

6.31 The problem of intimidation is also relevant in this case, as it is in many other cases nationally. Hannah and Adam repeatedly expressed that they would not support a prosecution. It is understood that the only time Richard was successfully prosecuted was when there was an independent witness and CCTV footage. This makes very clear the importance of robust evidence gathering in cases of domestic abuse where intimidation is very often relevant. The HMIC report into Police responses to domestic abuse in 2014 revealed that evidence gathering in cases of domestic abuse was often poor nationally. Prosecutions where the victim does not provide evidence at trial are more commonplace now and rely on evidence other than that given by the victim.

6.32 Repeat perpetrator

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6.33 There are reports of Richard using violence against males in public places and of violence towards police officers. Across the time span of 2010-2015 there was more often than not no further action taken, than prosecutions. In 2014, Richard escaped custody after being convicted of an assault against Hannah when he received a suspended sentence by promising to leave the UK and live abroad. However, he returned six weeks later, only part way through the suspended sentence period which was 12 months. He was never referred to any Perpetrator Programmes; if he had been these may have had a beneficial effect.

6.34 In this case the result of Richard's continued violence was that he himself was killed. It could very easily have ended with Adam or Hannah's death, especially as Richard was prone to strangulation assaults in a domestic setting. Strangulation assault is an acknowledged high-risk marker for future homicide and this should be given due weight in risk assessments.

6.35 Response to high-risk victims of domestic abuse

6.36 In this case Hannah was identified as a high-risk victim of violence. The process for high-risk victims was followed and referrals to MARAC and to Stonham were made. No referrals were made for Adam, and this is covered in the section re Adam as a victim of Domestic Abuse. The MARAC process was not effective or efficient in this case and it appeared that there was a lack of status given to the process more generally. There was poor information in the referrals, poor attendance and poor follow up with lack of actions.

6.37 The response to high-risk victims needs to include proactive information sharing and high status given to the process itself. This will be best served in strong leadership in all agencies in this area. MARAC should be seen as a key safeguarding process which can save lives, and given priority in terms of staff time, attendance, follow up and proactive information gathering and sharing.

6.38 Hannah also spoke about the complexity of their relationship and recognised that she was dependent on Richard in many ways, and this affected some of the choices she made (she was afraid of being alone and didn't want to grow old on her own). Hannah recognised the dysfunctional nature of the relationship but felt that the problems were rooted in Richard's mental illness and if he was given mental health support the problems could be addressed.

6.39 She was equally clear however, that she knew Richard would never leave her alone and described the relationship as heavily punctuated with unpredictable violence, control and abuse. Hannah lived her life in fear of Richard's violence.

6.40 Richard left the United Kingdom in 2014, on the premise that he would avoid a custodial sentence when convicted of a violent offence against Hannah (instead, he received a suspended sentence which is understood to have been

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on condition that he left the United Kingdom) but returned only six weeks later when the terms of the 12 month suspended sentence were still in place.

6.41 Richard's sister

6.42 Richard's sister remembered him as a caring and friendly person who struggled with life sometimes. She was concerned that Richard may be remembered in a very one dimensional way and wanted to give some balance to the way he may be perceived. She talked about the good characteristics he possessed, as did Hannah, which presents a more complex picture of the person Richard was.

6.43 Richard recognised he had problems and it is understood that he claimed that he suffered with bi-polar disorder and ADHD but there are no medical records to confirm this. He told Hannah he had medication but did not take it and this was the cause of his violence and unpredictability.

6.44 The GP surgery provided information which stated that Richard was an intimidating person who would insist that he was always seen by a female GP, and that the staff were frightened of him.

6.45 There are professional comments in the IMRs to suggest that Richard was controlling of Hannah and was very jealous and possessive, to the point that he even wanted her children to move out and was unpleasant and violent to them. It is also understood that he was also quite threatening to animals.

6.46 Information made available to the Panel demonstrates that there were communications between Richard and Hannah that show that he was pressuring her into sexual contact with strangers. The pressure was almost constant, but Hannah was very clear that she didn't like the idea and would not participate. However, the communications show a gradual breaking down of Hannah's resolve and eventual agreement to please him which created more trouble in the relationship.

6.47 Hannah's adult daughter declared herself homeless very soon after Richard moved in, in 2011 stating she was homeless because of Richard. At some point Hannah, Richard and the daughter had an argument. Richard went to apologise which turned into an argument, he assumed a threatening stance blocking the doorway and Hannah hit him in self-defence.

6.48 On three occasions Richard and Hannah were referred to MARAC by the Police but it was reported that on all occasions Hannah was unable to engage, presenting as not wanting support from services and refused their assistance. (Hannah was in a complex situation; she was embarrassed and she was scared. She would have to keep it a secret).

7. Conclusions

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7.1 In conclusion, when considering lessons to be learned from this case the key areas are around recognising high risk behaviours, considering risk to persons who may not be the primary victim, making decisions based on the best intelligence available and prompted by appropriate professional curiosity, and maintaining strong processes in response to high risk domestic abuse.

7.2 Adam and his mother were both at high risk of harm from Richard. The information to make this assessment was available to agencies.

7.3 There are already in place many responses, supportive actions, and sanctions to respond effectively, but they were not always used to their best effect.

7.4 It is recognised that since Richard's death there is new legislation which criminalises coercive and controlling behaviour in s76 of the Serious Crimes Act 2015. It is also recognised that since 2015 there have been some changes in Agency Policy and Practice which may address some of the issues addressed in this Review.

8. Lessons to be Learnt

Learning Opportunity 1

When a Homeless Application is made by a child i.e. a person under the age of 18 a joint assessment should be undertaken by the Housing Authority and Children's Social Care. If the child specifically states that the home environment is unsuitable, background checks should be performed on any named person who is the cause of the young person's concern before any decision is made which impacts on that person's safety.

Learning Opportunity 2

When considering risk and support, all agencies should consider the risk posed to any person within the household, especially any vulnerable person. In this case risk assessment and support was focused entirely on Hannah, when there are processes in place to support young people like Adam.

Learning Opportunity 3

Agencies to work collaboratively to gather intelligence and conduct background checks to inform any decisions and risk assessments where safety is an issue

Learning Opportunity 4

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Good knowledge around high risk markers and why they are high risk should be standard content in any domestic abuse training across all agencies. Key behaviours like strangulation, threats to kill and repeated violence should be given due weight in considering support and responses for victims.

Learning Opportunity 5

Consideration of intimidation should be central to the Police's assessment of any domestic abuse call for service. Where victims do not engage, accept help, or support prosecutions, intimidation should be considered and ways to alleviate fear explored with the victim.

Learning Opportunity 6

Raising the status of MARAC should be a priority for all agencies. Staff should be encouraged to give MARAC appropriate attention and should be given time to prepare and follow up actions. Professional curiosity should be encouraged and supported in all staff and this is a matter for strong leadership.

Learning Opportunity 7

Focus on perpetrators of domestic abuse, especially repeat offenders, should have a clear path for response for Police and criminal justice agencies. Full consideration of the options available should be considered for repeat offenders before no further action is considered. This should include perpetrator programmes.

9. Recommendations from the Review

Recommendation 1

In any Homelessness Application for young people, background checks on associated individuals should be performed to inform decisions where:

- there is any evidence of any domestic abuse against any person in the home environment,
- a problem person is named,

where either situation is the reason for the application.

Recommendation 2

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When any professional is performing a Risk Assessment, that risk should be considered in relation to any person within the household or sphere of violence. This would include anyone living with a high-risk perpetrator, or anyone subjected to domestic violence by them. Any person over the age of 16 subjected to such violence should be considered for referral to specialist Domestic Abuse Services and considered for Risk Assessment in their own right.

Recommendation 3

Where an individual has a history of violence or abuse this should be considered in any response by the Police and criminal justice agencies. Efforts to respond with Criminal Justice sanctions should be pursued, and proactive consideration of Perpetrator Programmes, Alcohol or Drug Misuse Programmes, or specialist Domestic Abuse, Mental Health or Stalking Interventions. Sanctions can be a way to access help. The Domestic Violence Disclosure Scheme should also be considered in repeat or high-risk cases.

Recommendation 4

All frontline professionals who may deal with disclosures of domestic abuse should have a good knowledge of the high-risk markers which predict harm and how to respond to them. For example, previous history, strangulation assaults, separation, pregnancy, escalation/increase in severity, harassment, stalking, threats to kill, substance misuse and alcohol misuse.

Recommendation 5

Whenever victims of domestic abuse fail to engage or will not support prosecutions, intimidation should be considered (look for CCTV and corroboration). This would include active consideration of safe disclosure away from the home and assurance of confidentiality from the perpetrator. Strengthen CPS engagement.

Recommendation 6

The status of MARAC should be raised with immediate effect. This should be achieved through strong leadership and prioritisation of MARAC attendance and actions.

Recommendation 7

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It was also noted that the commissioning cycle for domestic abuse service provision is very short and this is not helpful. It was considered a national recommendation was needed to stress the importance of consistency of such services for victims who are reliant on them. Commissioners should ensure appropriate service contracts to enable consistent service delivery.

Recommendation 8

A clear path for responding to repeat offenders should be easily accessible to frontline and custody officers and supervisors, pointing to the available options for responding. This could potentially be achieved through a clear Flowchart designed by individual agencies.

Recommendation 9

There could be encouragement for the PCC to fund Perpetrator Programmes and a domestic abuse integrated Offender Management Scheme.

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