Domestic Homicide Review
Executive Summary

Under s9 of the Domestic Violence, Crime and Victims Act 2004

Review into the death of Karen
in January 2018

Report Author: Christine Graham
April 2019

Preface

Mansfield's Community Partnership wishes at the outset to express their deepest sympathy to Karen's family and friends. This review has been undertaken in order that lessons can learned.

The Independent Chair and Report Author would like to thank the staff from statutory and voluntary sector agencies who assisted in compiling this report.

To protect the identity of the victim she is known as Karen throughout the report

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Section One – The Review Process

1.1 Introduction and agencies participating in the review

This summary outlines the process undertaken by Mansfield Community Safety Partnership Domestic Homicide Review Panel in reviewing the death of one of its residents. The death occurred in January 2018.

In order to protect the anonymity of the victim and her family members, she will be known as Karen.

The deceased was a white British female, aged 44 years. She has three sisters and a son of 28 years from a previous marriage. She has a father and step-mother and her mother had died some years previously.

Karen was killed by her partner who was 39 years old at the time of the incident. He has a history of criminality, drug taking, dishonesty and violence. He had no previous arrests or convictions for domestic violence. During the course of the police investigation however, information came to light that he had previously strangled a former partner to a state of unconsciousness. This was not evidence that was adduced before the court and for legal reasons it is not something that can be further explored in detail within this Review. It's relevance, however, is clear.

At approximately 6.30 pm on an evening in January 2018 the police forced entry to Karen's flat where they found her body under a duvet in the living room. The perpetrator was located the next evening at a local address following information given to the police. The pathologist concluded that Karen had died as a result of manual strangulation.

Mansfield Community Safety Partnership was notified of the death by Nottinghamshire Police on 1st February 2018. On 19th February 2018 the Chair of the Partnership chaired a meeting of the Partnership where it was decided that a review should be undertaken. The Independent Chair and Report Author were appointed in March and the panel met for the first time on 4th June 2018.

The coroner opened the inquest and it was adjourned waiting for the conclusion of the criminal process. The perpetrator pleaded guilty to manslaughter but at the conclusion of the trial, was found guilty of murder and sentenced to life imprisonment with a minimum term of 16 years.

As part of the review, IMRs[1] were completed by:

- East Midlands Ambulance Service
- Mansfield and Ashfield Clinical Commissioning Group (on behalf of the GPs)
- Mansfield District Council
- Nottinghamshire NHS Foundation Trust
- Nottinghamshire Police

The panel met for a further meeting to discuss the overview report and the review was concluded in April 2019.

It was not possible to complete the review within the six month timescale as the review could only proceed in limited scope until the criminal trial was concluded.

[1] Individual Management Reviews

The following agencies contributed to this review:

- CGL
- DLNR Community Rehabilitation Company
- Equation
- Mansfield District Council
- Nottinghamshire County Council
- Nottinghamshire Independent Domestic Abuse Services (NIDAS)
- Nottinghamshire Healthcare Trust
- Nottinghamshire Police
- Nottinghamshire Women's Aid
- Sherwood Forest Hospitals Trust (SFHT)

1.2 The Review Panel Members

The Panel was made up of the following members:

Gary Goose MBE	Independent Chair	
Christine Graham	Overview Report Author	
Susan Barnitt	Head of Quality and Adult Safeguarding	Mansfield and Ashfield Clinical Commissioning Group
Zoe Rodger-Fox	Head of Safeguarding	East Midlands Ambulance Service
Tina Hymas Taylor	Head of Safeguarding	Sherwood Forest Hospitals NHS Trust
Hannah Hogg	Safeguarding Lead	Nottinghamshire Healthcare NHS Trust
Julie Gardner	Associate Director for Safeguarding and Social Care	Nottinghamshire Healthcare NHS Trust
Nick Thornley	Nottinghamshire Safeguarding Adults Board	Nottinghamshire County Council
Mandy Green	Director of Services	Nottinghamshire Women's Aid
Sue Ready	Director of Service Delivery and Development	NIDAS
Adrian Thorpe	Men's Service Co-ordinator and IDVA	Equation
Michelle Turton	Housing Needs Manager	Mansfield District Council
Chris Fisher	Housing Operations and Safeguarding Manager	Mansfield District Council
Sarah Dodsley	Domestic Violence Prevention Officer	Mansfield District Council
Hayley Williams	Senior Investigating Officer	Nottinghamshire Police
Tony Webster		Nottinghamshire Police
Minesh Patel	Services Manager	CGL
Jonathan Webb	Deputy Head of Service	DLNR Community Rehabilitation Company
Nigel Hill	Head of Nottinghamshire	National Probation Service

1.3 Domestic Homicide Review Chair and Overview Report Author

1.3.1 Gary Goose served with Cambridgeshire Constabulary rising to the rank of Detective Chief Inspector, his policing career concluded in 2011. During this time, as well as leading high-profile investigations, Gary served on the national Family Liaison Executive and led the police response to the families of the Soham murder victims. From 2011 Gary was employed by Peterborough City Council as Head of Community Safety and latterly as Assistant Director for Community Services. The city's domestic abuse support services were amongst the area of Gary's responsibility. Gary concluded his employment with the local authority in October 2016. He was also employed for six months by Cambridgeshire's Police and Crime Commissioner developing a performance framework.

1.3.2 Christine Graham worked for the Safer Peterborough Partnership for 13 years managing all aspects of community safety, including domestic abuse services. During this time, Christine's specific area of expertise was partnership working – facilitating the partnership work within Peterborough. Since setting up her own company, Christine has worked with a number of organisations and partnerships to review their practices and policies in relation to community safety and anti-social behaviour. Christine also delivers Partnership Healthchecks which provide an independent view of partnership arrangements. Christine is also a Lay Advisor to Cambridgeshire and Peterborough MAPPA which involves her in observing and auditing Level 2 and 3 meetings as well as engagement in Serious Case Reviews.

1.3.3 Working together, Christine and Gary have completed four reviews, with eighteen reviews (excluding this one) currently in progress. In addition, Gary has completed six reviews working alone.

1.3.4 Neither Gary Goose nor Christine Graham are associated with any of the agencies involved in the review nor have, at any point in the past, been associated with any of the agencies.[2]

1.3.5 Both Christine and Gary have:

- Completed the Home Office online training on Domestic Homicide Reviews, including the additional modules on chairing reviews and producing overview reports
- Completed DHR Chair Training (Two days) provided by AAFDA (Advocacy After Fatal Domestic Abuse)
- Attended the AAFDA Annual Conference (March 2017)
- Attended training on the statutory guidance update in 2016
- Undertaken Home Office approved training in April/May 2017
- Attended the AAFDA Annual Conference (March 2018)
- Attended Conference on Coercion and Control (Bristol June 2018)
- Attended AAFDA Learning Event – Bradford September 2018
- Attended AAFDA Annual Conference (March 2019)

[2] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (para 36), Home Office, Dec 2016

1.4 Purpose and Terms of Reference for the Review

According to the statutory guidance, the purpose of the DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result
- Apply these lessons to service responses including changes to policies and procedures as appropriate
- Prevent domestic violence and homicide and improve service responses to all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest possible opportunity
- Contribute to a better understanding of the nature of domestic violence and abuse
- Highlight good practice

The Panel agreed that the specific purpose of the Review is to:

- Establish the facts that led to the incident in January 2018 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the victim.

- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.

- Establish whether the agencies or inter agency responses were appropriate leading up to and at the time of the incident in January 2018; suggesting changes and/or identifying good practice where appropriate.

- Establish whether agencies have appropriate policies and procedures to respond to domestic abuse and to recommend any changes as a result of the review process.

- Contribute to a better understanding of the nature of domestic violence and abuse; and

- Highlight good practice

The scope of the review, as agreed by the Panel, is to:

- Seek to establish if the events in January 2018 could have been reasonably predicted or prevented.

- Consider the period of two years prior to the events (unless there are significant incidents prior to this date), subject to any information emerging that prompts a review of any earlier incidents or events that are relevant.

- Request Individual Management Reviews by each of the agencies defined in Section 9 of The Act and invite responses from any other relevant agencies, groups or individuals identified through the process of the review.

- Seek the involvement of family, employers, neighbours & friends to provide a robust analysis of the events.

- Produce a report which summarises the chronology of the events, including the actions of involved agencies, analyses and comments on the actions taken and makes any required recommendations regarding safeguarding of individuals where domestic abuse is a feature.

- Aim to produce the report within the timescales suggested by the Statutory Guidance subject to:
    - guidance from the police as to any sub-judice issues,
    - sensitivity in relation to the concerns of the family, particularly in relation to parallel enquiries, the inquest process, and any other emerging issues.

Section Two – The Facts
Agency contact and information learnt in the review

Karen was a woman with long standing mental health problems including depression and alcohol abuse. In November 2017 she reported that she was suffering with agoraphobia, severe anxiety and manic depression. At times she experienced thoughts of self-harm.

The perpetrator had a long criminal record going back to his teens. He was convicted of Actual Bodily Harm against a 15-year-old when he was 17 years old. His most recent offences were drug offences, driving offences, theft from shops and affray. He has a long history of drug and alcohol abuse, going back to his early teens and had been receiving interventions from appropriate services over the years. The perpetrator experienced mental and behavioural disorders due to opiate dependence syndrome. At the time of the incident, he was on a methadone prescription to assist his withdrawal from heroin.

From the information available to the review, we believe that the relationship between Karen and the perpetrator began at some time after the end of August 2017 when Karen moved into a room in the house in which the perpetrator already had a room.

Agencies had little or known contact with the victim, other than with her GP. The perpetrator also had contact with his GP. The couple lived in privately rented accommodation. Despite each renting a room and claiming benefits as a single person, the review has been told that they lived together. For this reason, their relationship was 'hidden' to agencies.

The review fully respects that Karen's family did not wish to contribute of this review, but it has led to a very limited understanding about her and her relationship with the perpetrator.

Section Three – Key issues arising from the review

Whilst undertaking this review, it has been very difficult to gain a picture of the relationship between Karen and the perpetrator. We know that they met when Karen moved into a house of bedsits in which the perpetrator was already living. We believe that they had been in a relationship for 7-8 months prior to the incident.

We know that the perpetrator had a history and propensity to be violent and abusive towards women to whom he was close. It is therefore not unreasonable to suggest that there was abuse and/or coercion in the relationship. The highest risk behaviour for predicting future homicide is a prior history of domestic abuse[3].

We know that Karen was vulnerable due to her physical and mental health issues. However, we do not know the impact that these had on her day-to-day life other than to be aware that she had suffered with agoraphobia for a number of years.

We know that at the end of November, Karen made a Homefinder application to seek a move for herself. On this application she did not give reasons for her move, but she did not indicate that the perpetrator would be moving with her to this new property. This raises the question about whether she intended to leave him. We do not know if he knew about this application or the seven bids she made on properties before her death. We do not know what the couple were arguing about on the evening of her death, but we do know that the biggest trigger for domestic homicide is separation or the threat of separation[4].

[3] Domestic abuse, homicide and gender, Jane Monkton Smith, Amanda Evans and Frank Mullane, Palgrave Macmillan, 2014
[4] Domestic abuse, homicide and gender, Jane Monkton Smith, Amanda Evans and Frank Mullane, Palgrave Macmillan, 2014

Section Four- Conclusions

This is a very sad case of a young lady who was struggling with life. She was isolated due to her agoraphobia and did not have a network of friends to support her. Unfortunately, the review has been unable to really understand what her life was like on a day-to-day basis and, most importantly for the review, the level of domestic abuse she was subject to.

Unfortunately, the circumstances of her death mean that Karen's family are left with a number of unanswered questions – about her life and about how she met her death.

The review panel extends its sympathies to the family and friends.

Section Five – Recommendations

Mansfield and Ashfield Clinical Commissioning Group on behalf of GP contracted services

6.1 It is recommended that GPs routinely demonstrate professional curiosity by asking an open question such as 'how are things at home' and use the response to these questions to make appropriate referrals to DARS (Domestic Abuse Referral Service).