DOMESTIC HOMICIDE REVIEW CASE 4:

EXECUTIVE SUMMARY

JANUARY 2015

Safer Devon Partnership

INTRODUCTION

1. This report of a domestic homicide review undertaken by the Safer Devon Partnership (SDP) on behalf of East and Mid Devon Community Safety Partnership (CSP) is to review the death of Subject A, who was killed by her son Subject B in Devon in July 2012. Subject B was convicted of murder in July 2013 and is serving a prison sentence of 15 years.

2. The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future. The report examines engagement between agencies and Subject A, Subject B and their family and friends prior to Subject A's death.

3. The review was conducted by a panel with an independent chair and representatives of :
    - Devon County Council (Adult Safeguarding)
    - East Devon District Council
    - Devon & Cornwall Police
    - Devon Drug and Alcohol Action Team
    - Adva (until February 2014)

4. The Independent Chair, who has experience of previous DHRs, has knowledge of community safety, partnerships and domestic abuse, has never been employed by any of the agencies concerned with this review, and has no personal connection to any of the people involved in the case. No members of the panel had any prior direct involvement with the events or decisions covered by the review, or management responsibility for the staff whose actions are described.

5. The review report draws on information and analysis from the agencies which were potential support agencies for Subject A and Subject B prior to Subject A's death. A number of local agencies checked their past contacts with Subject A and Subject B and Subject B's family members. Relevant records of involvement were identified by the Ahimsa (a male perpetrator service in Plymouth), Cafcass (Children and Family Court Advisory and Support Service), Devon County Council (Children and Young People's Service), Devon and Cornwall Police and Stop Abuse for Everyone (SAFE) – a voluntary specialist support service for domestic abuse victims.

6. The review was initiated in July 2012, following the death of Subject A. The confirmation of terms of reference and preparation of individual management reviews (IMRs) by agencies was deferred until after criminal proceedings were completed in July 2013. IMRs were prepared by Cafcass, Devon County Council (Children and Young People's Service), and Devon and Cornwall Police.

7. The panel drew up an overview report based on these, other information about local services and conversations with family and friends of the victim. This was submitted to the Home Office for quality assurance in September 2014, with approval received in December 2014. The overview report is available to the agencies responsible for responding to domestic abuse, but is not in the public domain to protect the privacy of those, (other than the victim and perpetrator), whose story is necessarily told in this report, and who might be identifiable even though their names are not used. These include children.

CIRCUMSTANCES OF THE HOMICIDE

8. Subject A was murdered in her bedroom at home on 11th July. The previous week, Subject A had been on holiday with a female friend. Subject B had remained living in her house in Town X, as he had since February that year.

9. On 8th July, after Subject A had returned from holiday, she had an argument with Subject B on discovering evidence that he had used drugs in the house. The judge, in sentencing Subject B, described it in this way: "Your mother had allowed you to live in her house, but on the clear understanding that if you did bring drugs into the house she would tell you to leave. Two days before the killing she had found evidence that you had been using cocaine. She found an empty wrap in your bedroom and there was a row between the two of you." On 10th July Subject B attended the weekly Narcotics Anonymous (NA) meeting in Town X, as was his usual practice.

10. Subject B admitted purchasing 2 grams of cocaine later in the evening of 10th July and taking about 1¼ grams of it at Subject A's house that night He had not drunk any alcohol that day, and was taking prescribed medication for depression at that time.

11. Subject B and Subject A were alone in the house at the time of the homicide. The judge, in sentencing remarks, summed up the events as follows. "On the evening of the killing you had succumbed again to your addiction and bought cocaine which you took home and consumed on your own evidence in the bath to increase its effect. As a result your mother found more empty wraps in your bedroom….. You reacted in anger…….. to whatever it was that she reasonably and justifiably said to you, and you assaulted her injuring her…… and you then throttled her with [a] belt and strangled her to death." The post mortem found that Subject A had significant blunt trauma to her face and head with strangulation marks, indicating the use of a ligature, around her neck. He was found guilty at Crown Court. The judge said, in his remarks on sentencing, that "there could be no realistic doubt whatsoever that you intended at the time to kill her".

ANALYSIS

Was there a record of domestic abuse?

12. None of the agencies contacted for this review received any contact from Subject A or members of her family about domestic abuse of Subject A, either by Subject B or any husband or partner. However, several agencies (the Police, Devon CC, Cafcass, Ahimsa, SAFE and Subject B's GP) were involved in dealing with domestic abuse by Subject B of a former partner, Subject E.

13. The Review Panel has considered agency responses to known abuse of Subject E by Subject B, and her concerns about his propensity to violence, to establish whether they acted in line with policy at the time, and whether there were missed opportunities to intervene which might have influenced Subject B's subsequent behaviour and potentially prevented the homicide. According to the family, Subject A was aware of Subject B's behaviour towards Subject E.

14. The relationship between Subject B and Subject E was described by Subject E as turbulent and violent. It lasted from 2003 to 2009, and was followed by disputes over debts and his contact with their child, Child F, which continued up to the time of the homicide. Various agencies became involved, including Devon and Cornwall Police, and Subject B was cautioned for assault in 2005 and 2009. Earlier In 2009 Devon CC's Children and Young People's Services (CYPS) had been alerted to the impact of domestic abuse in the family reported by the primary school attended by two of Subject E's older children. Cafcass undertook a risk identification which covered domestic abuse during 2010 when Subject E applied for family court orders in respect Subject B's contact with Child F.

Could the homicide have been predicted or prevented?

Prediction

15. The homicide could not have been predicted. Subject B, as a result of his offending history, particularly the use of choking, in addition to his drug and alcohol abuse, presented a potential risk to any person with whom he had a personal relationship. However, there was nothing in his previous behaviour to Subject A that led her or other family members to regard her as at risk, until the argument which followed her first discovery of cocaine wrappers in the home. This was known to some family members, but not to any agencies. Subject B behaved normally over the next two days, attending work and a local NA meeting. No-one other than the contact from whom he bought cocaine late on the evening of 10th July was aware that he was repeating the behaviour that brought him into conflict with his mother.

16. Agencies were not in a position to see any risk that Subject B posed to his mother, as they had no contact with her about either domestic abuse or substance misuse. So far as can be known, Subject A had not previously been the victim of either violence or coercive control, from Subject B or any other man.

On the day

17. The homicide could have been prevented by an intervention to stop Subject B obtaining and using cocaine on 10th July. However, no agency was in a position to do this. The second argument, which ended in the murder, was precipitated by Subject A's discovery of fresh evidence of Subject B's cocaine use in her house. It is possible that the influence of the drug on his mood was also a factor, although this is not something on which the Review Panel has an expert view. Subject B obtained the cocaine from a contact already known to him at a residential address in Town X. While police aim to disrupt the supply of illegal drugs, including cocaine, national policy recognises that restricting rather than eliminating availability is the realistic aim. Subject B had also been able, that evening, to access support in tackling his addiction, through the local NA group, and yet still chose to seek out the drug.

Prevention – through victim awareness of risk

18. Agencies had no direct opportunity to assess the risk posed to Subject A of having Subject B in her home, or to warn her of it. She made no contact with them about her son, and he did not, in the contacts he had with police and his GP during the period he lived with her, indicate any hostility to her.

19. There is no indication that Subject A perceived herself to be at risk, and her relationship with her son was perceived by family and colleagues as good. It is unlikely, therefore, that the initiatives taken in East Devon to raise awareness of domestic abuse affected her view. However none had drawn attention to the fact that abuse can be directed against parents rather than at partners.

20. Subject A was supportive of her son's efforts to end his misuse of drugs and alcohol. So far as is known she did not seek any professional advice on this, or contact with other parents facing similar problems. It is possible that such contact might have encouraged her to consider her own safety. There are support groups in Devon (though not Town X) for families of drug and alcohol users, but Subject A is unlikely to have known of them as they are promoted through treatment services. The mutual aid groups helping Subject B, NA and AA, do not, as a matter of policy, pass on information about other services.

Prevention – through a perpetrator course

21. We do not know whether successful completion of a perpetrator programme by Subject B would have prevented the homicide. Such programmes have some success in changing attitudes and behaviour, and might have helped him establish a more stable life rather than end up living with his mother and turning back to drugs in 2012. They include training in dealing with anger, which might possibly have led to a less violent outcome on the night of 10th July. However, it is unknown whether the approach would have worked for Subject B.

22. The Police had been informed to two assaults by Subject B on Subject E. Had these been dealt with at court as certainly should have been in the case in the second instance, Subject B might have been convicted with order to attend offending behaviour programmes, specifically IDAP (Integrated Domestic Abuse Programme). Subject B was directed to a perpetrator course in 2010, through the Family Proceedings Court. The location of the course was some distance from his home and this is likely to have been a factor in his failure to complete it, but it cannot be known whether he would have persisted with a more convenient alternative either.

Prevention – through tackling underlying problems

23. As cocaine use was the trigger for the argument that resulted in the homicide, it could have been prevented by successful intervention in Subject B's cocaine habit. However, there is no assurance that he might not have reacted in the same way to a different domestic dispute with his mother. While alcohol misuse was not a direct factor in the homicide, it may have played a part in the instability of Subject B's life which led to him living with her. The ending of a relationship in which substance misuse may have been a factor, appears to have been a source of distress and the trigger for him moving in with his mother, despite owning an unoccupied house in the town.

24. Subject B was able to access some help through his GP practice, who encouraged him to talk about his situation, attend NA and AA, and source some independent counselling. They also prescribed anti-depressants to manage his mood. However they did not refer him to any specialist service, either as a survivor of abuse or to address his substance misuse. It is not possible to know whether these might have made a difference.

WHAT CAN BE LEARNED TO IMPROVE FUTURE PRACTICE?

25. This review has identified errors made by both police and social workers, particularly in responding to events in 2009. These were not due to weaknesses in policy, but to front line staff misjudging the situation and not following correct practice for the time, and to supervisors not challenging their action. This remains an ongoing risk for all agencies. The use of anonymised case studies and approaches such as appreciative enquiry can help staff to reflect on and improve their practice.

26. The police should, according to their own guidance, have prosecuted Subject B rather than cautioning him for his assault on Subject E in 2009. Checks conducted as part of this review have identified that cautioning remains too frequent a choice in domestic abuse cases in parts of Devon.

27. Both police and social workers failed in 2009 to give due attention to the fact that there had been previous domestic abuse. This was in their records, but for the Children and Young People's Service (CYPS), only on paper, and police did not check on Subject E's previous surname. On the other hand Cafcass took

appropriate account of the history of the relationship. Good systems and practice in using past records are important for accurate risk assessment.

28. While the response to domestic abuse rightly gives attention to the needs of the victim, this case has highlighted the importance of a parallel focus on the perpetrator. In dealing with Subject B's domestic abuse of Subject E, agencies noted when he was no longer living with her, but did not consider where and with whom he was living and whether anyone else was therefore at risk. Both the CYPS assessment and the police decision 2009 reflected the misconception that once a perpetrator has left the home domestic abuse is no longer a risk. Difficulties retrieving records by the name of the perpetrator add to this problem.

29. It seems likely that childhood sexual abuse played some part in shaping Subject B's character. He acknowledged this to some extent in seeking help as an adult in dealing with his troubled relationships and substance misuse, and did eventually access some counselling. However, so far as is known, he did not obtain help from any agency specialising in working with survivors of childhood abuse. The long term consequences of abuse are complex, and it is important for those to whom disclosure of historic abuse may be made to know what help they can signpost for survivors.

30. Ensuring that people know of and are able to access the services which are in place to help needs continued effort. While advice and support groups would have been available to Subject A, had she sought advice as a parent of a troubled adult, this is not well publicised. The fact that domestic abuse services help parents whose adult children are violent to them is not often cited in publicity. There are support groups for families of substance misusers in Devon, but information about them is directed to those already receiving treatment. It is not clear why Subject B's GP did not offer referral to NHS treatment for his drug and alcohol misuse.

31. The mutual support groups Alcoholics Anonymous and Narcotics Anonymous played an important role for Subject B in his attempts to sort out his life. No other services to address his substance misuse were offered to him. In this context, it is unfortunate that the philosophy of these groups prevents them from contributing to the learning from untoward events. Ways round this should be sought at national level.

32. The review also found good practice. There was multi-agency recognition of the importance of domestic abuse, and agreed arrangements for risk assessment. There was action to raise awareness among the public and front line staff. Services for both victims and perpetrators were provided, and did cater for violence to parents by adult children. Some front line staff responded well: teachers were alert to the link between witnessing domestic abuse at home and troubling behaviour at school; SAFE staff were persistent in making initial contact with Subject E and provided her with relevant and clearly documented support which improved her situation; and the Cafcass advisor (a trainee) handled the case well.

RECOMMENDATIONS

33. These recommendations include ways to continue good practice found in this case, as well as addressing areas where services could have done better.

R1 Ensure that the use of cautioning across the Force in domestic abuse cases is in line with national guidance and local benchmarks.

R2 Ensure that social workers retrieve paper based records, where available, as well as electronic records of historic contact with families when assessing current cases.

R3 Ensure social workers assessing the risk to children understand the impact of domestic abuse, recognising the harm to children from witnessing it and the heightened risk after the perpetrator has left the family home.

R4 Encourage agencies working with domestic abuse victims to be alert to evidence of perpetrators having more than one victim.

R5 Provide guidance to clinicians and other frontline staff on how to respond to disclosure of past abuse, including adults disclosing abuse in childhood, and on how to point such survivors to appropriate support.

R6 Ensure effective communication to all front line professionals of what services addressing alcohol misuse, drug misuse and domestic abuse are available, and of how to refer or signpost clients to them.

R7 Encourage learning by professional staff and their supervisors through an appreciative enquiry approach wherever possible.

R8 Safer Devon Partnership to consider abuse of parents by adult children among the themes for periodic domestic abuse awareness raising campaigns.

R9 Make information about support groups for families of substance misusers more widely available, recognising that not all will be in contact with treatment services.

R10 (National – Public Health England) Encourage Public Health England to work with Narcotics Anonymous and Alcoholics Anonymous, though their national bodes, to review their Safeguarding processes and protocols to assist in responding to serious incidents involving anyone attending one of their groups.

Letter received from the Home Office in response to the report:

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Home Office

Councillor Roger Croad
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8 December 2014

Dear Councillor Croad,

Thank you for submitting the Domestic Homicide Review (DHR) overview report for Devon to the Home Office Quality Assurance (QA) Panel. The review was considered at the November Panel meeting.

The QA Panel would like to thank you for conducting this review and for providing them with the final overview report. 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.

The QA Panel would like to commend you on the efforts made to obtain information for this review from a variety of sources, including applying to court to access information and researching the level of cautioning used in the local area. They felt the report appeared open and honest, with good analysis.

There were some issues that the QA Panel felt might benefit from more detail and/ or consideration which you may wish to consider before you publish the final report:

- Review the Action Plan to ensure the plan links to the report and its findings. Add a RAG rating and specify how your CSP is going to oversee delivery of the actions;
- Revisit the flow of the narrative and consider the use of pseudonyms to assist the reader;
- Clarify paragraph 6 of the Executive Summary, as it reads as though the DHR was started due to the family notifying the CSP of the need to conduct one;
- Additional text to clarify the independence of the Chair, and DHR Panel. Also add their names and roles;
- The QA Panel felt that the report required proofing to ensure typographical and format errors are corrected, to ensure a professional looking report;

- The QA Panel felt the report would benefit from further text to make it appear more victim focussed, and to balance the narrative regarding the perpetrator's abuse of his former partner; and,
- The QA Panel noted that the Executive Summary incorrectly states the report was sent to the Home Office in August 2014. The Home Office can confirm that the complete bundle was received by the Home Office on the 17th September 2014. Please amend this and also clarify in the overview Report whether a draft has been shared with the family.

The QA Panel notes the action for Public Health England (PHE) in recommendation 10 at page 30, and can confirm that Home Office will take this up with their PHE counterparts to raise awareness of the statutory duty to contribute to these reviews.

The QA Panel also notes your arguments in support of not publishing. However the Statutory Guidance requires compelling and exceptional circumstances to agree that publication should be withheld. In this instance the QA Panel considered your reason offered – privacy of the family - and felt that this was not sufficient on its own to stop publication. They also suggest that removal of references to the children's gender may also help to further anonymise this review.

The QA Panel would of course be happy to hear further from you on this point and would consider any further reasons submitted in accordance with paragraphs 75, and 96 of the Statutory Guidance, before the 27 February 2015.

The QA Panel notes your reference to difficulties with GP participation and will work with the Department of Health, NHS England and PHE to consider this point.

The Panel does not need to see another version of the report, but we would ask you to include our letter when you publish the report.

I would like to thank you once again for submitting this thorough report for consideration by the Home Office Domestic Homicide Review Quality Assurance Panel.

Yours sincerely,

Christian Papaleontiou, Chair of the Home Office Quality Assurance Panel

Head of the Interpersonal Violence Team, Safeguarding & Vulnerable People Unit