DOMESTIC HOMICIDE REVIEW

Overview Report – Independent Author Kate Gallopi

Executive summary

Report into the death of 'Adult K'

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INTRODUCTION:

This is the executive summary of the Domestic Homicide Review that followed the tragic death of Adult K resident of Leicester, who was killed as a result of domestic abuse by her son Mr. K Mr. R on the 16th of July 2013. Adult K was married, the husbands identify is protected within the report. .

Our deepest condolences are sent to the family of Adult K.

The key purpose of undertaking a Domestic Homicide Review (DHR) is to enable lessons to be learned about 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 review has considered agencies contact and involvement with Adult K victim and her son (perpetrator). The full report providing further detail and analysis of agencies involvement is available at http://www.saferleicesterpartnership.gov.uk;

1 THE REVIEW PROCESS:

1.1 This summary outlines the process undertaken by a Leicester DHR panel in reviewing the murder of Adult K. At the criminal trial Adult K's son pleaded guilty to murder, early in 2014; he received and twenty one and a half year sentence.

1.2 The Safeguarding Board Manager contacted 40 agencies to establish local contact with the family members; the trawl of information covered the period July 2008-July 2013, following the Death of Adult K. The Domestic Homicide Review process began with an initial meeting on 27th January 2014 of involved agencies.

1.3 Family, friends and work colleagues were considered by the panel to be integral to the review process to help build a picture of Adult K's life. In line with the Domestic Homicide Review guidance the husband, son (perpetrator) and daughter of Adult K were contacted and asked if they wished to contribute to the review, and receive a copy of the final report. However, the family declined the offer to contribute to the review, and advised that they 'wished to move on'. The panel gave careful consideration to following this line of enquiry further, but they concluded that the family wishes should be respected.

2 TERMS OF REFERENCE;

2.1 **The terms of reference for the review were to:**

- Review the involvement of each individual agency, statutory and non- statutory, with Adult K' and her Son between 2011 and 16th July 2013.
- Summaries the involvement of agencies prior to July 2013.
- Provide a chronology of agency involvement with Adult K and her Son during the time period.
- Search all their records outside the identified time periods to ensure no relevant information was omitted.
- Provide an individual management review if necessary: identifying the facts of their

involvement with Adult K.' her Son', critically analysing the service they provided in line with the specific terms of reference; identifying any recommendations for practice or policy in relation to their agency.

In order to critically analyse the case, the terms of reference required specific analysis by the panel of the following:

- Communication and co-operation between different agencies involved with the couple.
- Was the Adult K's death 'isolated incident' or were any warning signs meaning the incident was preventable or predictable.
- Opportunity for agencies to identify and assess domestic abuse risk.
- Agency responses to any identification of domestic abuse issues in relation to ' Adult K'
- Quality of oversight and supervision of staff engaging with the victim and perpetrator was this deemed adequate.
- Organisations access to specialist domestic abuse agencies.
- The training available to the agencies involved on domestic abuse issues
- Review the care and treatment, including risk assessment and risk management of the Adult K's Son in relation to his primary and secondary mental health care.

For the panel to:

- Ensure the review is conducted according to best practice, with effective analysis and conclusions of the information related to the case.
- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence including their children.
- 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; and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

2.2 Agencies and individuals who produced written reports supporting the DHR review:

Agency Name	Involvement Type	Time Period	Involvement with member of family
Leicester City Council housing Department	Social housing provider	2001-2013	Adult K and Husband
University Hospitals Leicester	Patient records	2012 -2013	Adult K's Son
Health care Centre	Primary care agency		

2.3 A trawl of agencies information [1] was sent on 21st August 2013 with a ten day deadline 5th September 2013 for response. All agencies complied with the request, but a significant number of those agencies submitted nil returns, as they had no contact with Adult K, her son or her husband. Leicester City Council - Safer Communities Department – there was no direct involvement but supported the DHR panel representing specialist domestic violence services.

2.4 Agencies who submitted an Independent Management Review to the process provided:

- Chronology of interaction with victim, perpetrator or children
- A report of their involvement according to terms of reference for the review
- Conclusions and recommendations from agency's point of view.

3 KEY ISSUES ARISING FROM THE REVIEW:

3.1 Background

There was limited agency involvement prior to the death of Adult K; there was also no reported history of domestic violence by members of this current household in Leicester, prior to the murder and therefore no key "warning signs". The family GP's were the only professionals who had substantive contact with Adult K's son and Adult K prior to this incident; the son was diagnosed and treated for depression and headaches. The review panel wished to highlight the GP involvement with the family as exemplary in the medical support provided.

4 CONCLUSIONS & RECOMMENDATIONS

4.1 The role of a DHR is to consider whether the homicide appears to be an 'isolated incident' or whether there were any warning signs meaning the incident was preventable or predictable. This should include whether the deceased had experienced

[1] For a list of those agencies 'trawled' please see Appendix B of the main report The full report providing further detail and analysis of agencies involvement is available at http://www.saferleicesterpartnership.gov.uk;

domestic abuse within her family dynamics, and whether these were known about by agencies; and whether agencies were aware of the alleged perpetrator having any previous history of abusive behaviour or substance misuse to suggest any indication that he was capable of such an act.

The answer to these questions in the case of the murder of Adult K is no. The information provided by agencies identified there were no reports of domestic abuse between Adult K and her son; and no suggestion that Adult K's son was capable of committing this act. The review panel concluded that this murder was not predictable and could not have been prevented.

Given these findings there are limited recommendations arising from this DHR for local agencies on lessons learned on supporting victims of domestic violence, as this appeared to be an isolated incident. However, the panel would like to recommend that whenever anger management issues are identified a follow up question is always asked as to how this is impacting on the family; and a routine enquiry about domestic violence is followed by practitioners, and embedded in practice. It is proposed that a local resource be developed that encapsulates this recommendation.

Adult K's son was witness of domestic violence as a young child; between his mother and an ex-partner when the family lived in Derbyshire. Adult K separated from this abusive relationship and moved the family to Leicester, where she married her current husband and there was then a period of stability.

Leicester has raised awareness of learning from National and Local DHR's within a joint conference delivered by SAFER Leicester Partnership and the Local Safeguarding Boards, November 2014.

To conclude, sadly this horrific murder of a mother by her son is one which could not have been predicted or prevented. The panel however wanted to emphasise the good practice points in working with the son of Mrs K when anger management was an identified issue, the following actions across agencies are being taken forward, see appendix 1 for full action plan.

- A local general practice resource is developed that includes prompts to explore the impact of anger management behaviour on the family, to disseminate good practice arising from this review.

- Routine enquiry into domestic violence is embedded within general practice whenever anger issues are identified.

- Importance of routine enquiry on impact on family members when anger is identified as a problem has been emphasised to local agencies.

- Share learning to staff from National and Local Domestic Homicide Review's- workshops held within Joint Safeguarding Conference held November 2014.

4. Glossary

DHR	Domestic Homicide Review
DCI	Detective Chief Inspector
LSAB	Leicester Safeguarding Adults Board
CSP	Community Safety Partnership
SLP	Safer Leicester Partnership
LSCB	Local Safeguarding Children Board
MCA	Mental Capacity Act
DoLS	Deprivation of Liberty Safeguards
DV	Domestic Violence
GP	General Practitioner
DVIRP	Domestic Violence Integrated Response Project (known as FreeVA – 'Free from Violence and Abuse' from August 2013)
LWA	Living Without Abuse
WALL	a non-profit-making organisation affiliated to Women's Aid
EMAS	East Midlands Ambulance Service
MIU	Minor Injuries Unit
SSAFA	Soldiers, Sailors, Airmen and Families Association
LCC	Leicester City Council
YOS	Youth Offending Service
LASBU	Local Anti-Social Behaviour Unit
CAFCASS	Children and Family Court Advisory and Support Service
UHL	University Hospitals of Leicester
LPT	Leicestershire Partnership Trust
FLO	Family Liaison Officer
DOB	Date of Birth
IMR	Individual Management Report / Internal Management Review (used interchangeably)
OVR	Overview Report
PHQ-9	a nine item depression scale of the Patient Health Questionnaire for assessing and monitoring depression
ABH	Actual Bodily Harm
ED	Emergency Department
DVD	Digital Versatile Disk
MAPPA	Multi-Agency Public Protection Arrangements
MARAC	Multi-Agency Risk Assessment Conference
NSPCC	National Society for the Prevention of Cruelty to Children
NHS	National Health Service

Appendix 1 Action plan

Recommendation	Action to take	Lead Agency	Key milestones to take enacting the recommendation	Target Date	Agency Progress
It is noted that the self help guide used by the GP was developed by another area. We recommend a local resource is developed that includes prompts to explore the impact of behaviour on the family	Review what self- help guides are used across Leicester by GPs for discussing depression and anger management with a patient. If appropriate develop standardised local self help guide(s) adapted from best practice models.	Leicester CCG	Circulate help guide amongst group of local GPs Comments received from local GPs local guide developed and signed off for use March 2015 self help guide in circulation	January 2015 Sept 2015	Draft proposal outlining an adapted version of the IRIS model, developed in partnership (Head of Adult Safeguarding CCG, Head of Community Safety and the DV coordinator from LCC) submitted to the CCG. CCG working with Jenkins centre to produce a resource to support GPs
A routine enquiry into domestic violence is embedded within general practice whenever anger issues are identified.	GP engagement plan, with specific tools and practice documents as necessary	Leicester CCG	GP engagement in DVDG action plan GP and IDVS link people identified Joint Safeguarding Conference includes relevant workshops Comments received from GPs and local IDVS on self help guide on anger Review need for additional actions April 2015 review report on routine enquiry following identification of anger issues and general referral levels from GPs into IDVS	April 2014 June 2014 Nov 2014 February 2015	Draft proposal outlining an adapted version of the IRIS model, developed in partnership (CCG, CSP, DV LCC) submitted to the CCG CCG working with Jenkins centre to produce a resource to support GP's.

Recommendation	Action to take	Lead Agency	Key milestones to take enacting the recommendation	Target Date	Agency Progress
Emphasis to agencies importance of routine enquiry on impact on family members when anger is identified as a problem	Review strategy and action plan	Community Safety (LCC)	Review information collated. Review Report drafted Draft Strategy ready 31/3/15 inter-agency domestic violence and sexual violence strategy is signed off by partners including city council; LSAB; LSCB; Police; NGOs; CCG with live action plan for annual delivery	August 2015	Planning session held 26th Feb. Draft Strategy expected end August 2015
Share learning from Domestic Homicide Review	Hold X2 workshops on lessons learnt from DHRs and SCRs at the joint safeguarding board and domestic violence delivery group conference on the 4th November 2014 aimed at frontline professionals, students and academics.	(LSAB) Strategic Plan for 2013/14.	Presentation drafted and key interactive questions to be asked of the audience by the workshop facilitator to be agreed by the Adult Review and Learning Group. September 2014. Evaluation forms to be completed post event by attending delegates. Evaluation forms to be reviewed and comments made in the workshops. Feedback from workshop provided to November ARLG meeting	04/11/14	 Learning Lessons.pptx Completed Discussion from workshops summarised for ARLG - WB 10.11.14