EPPING FOREST COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW EXECUTIVE SUMMARY

Case of Mary, November 2017

Domestic Homicide Review Chair and Report Author: Althea Cribb

Domestic Homicide Review completed: September 2019

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1. Review Process

1.1. This summary outlines the process undertaken by the Southend Essex and Thurrock Domestic Homicide Review Team and Epping Forest Community Safety Partnership in reviewing the homicide of Mary who was a resident in their area. Mary was killed by her grandson, Douglas.

1.2. The following pseudonyms have been in used in this review for the victim and perpetrator to protect their identities and those of their family members: victim, aged 94, Mary; perpetrator, aged 32, Douglas. Both Mary and Douglas were recorded as being of white European ethnicity.

1.3. Criminal proceedings were completed in October 2018. Douglas pleaded not guilty to murder and pleaded guilty to manslaughter on the grounds of diminished responsibility. In October 2018 Douglas was convicted of murder; the jury did not accept Douglas's defence.

1.4. The process began with a meeting of the Southend Essex and Thurrock Domestic Homicide Review Core Group in December 2017 when the decision to hold a Domestic Homicide Review was agreed. All agencies that potentially had contact with Mary and/or Douglas prior to the point of death were contacted and asked to confirm whether they had been involved with them. The Core Group agreed, on the basis of the scoping information gathered, that the DHR would be delivered at 'Level 3': A single or twin agency review, or for cases where no relevant information was held by any agency. A partnership event would be held to consider the case and to capture key issues to be written up in the DHR report. All would be sent to the Home Office for review by the QA Panel and published once approved as per current arrangements.

1.5. Eight of the agencies contacted confirmed contact with Mary and/or Douglas and were asked to secure their files. Individual Management Reviews (IMRs) and chronologies were sought from those agencies. A partnership workshop was held to consider the case and to capture key issues and learning. The Overview Report was then shared with the workshop attendees for comment and feedback. The Home Office Quality Assurance Panel approved the publication of the DHR.

1.6. Due to the impact on the family of the homicide and the Review, the CSP and SETDAB decided not to publish the Review. This Executive Summary has been produced to be shared with partners so that the learning is disseminated. It is confidential and should not be shared publicly.

2. Contributors to the Review

2.1. The following agencies contributed information to the DHR:

Agency	**Submission made**
Barking, Havering & Redbridge University Hospitals NHS Trust	Chronology
Care Home A	Chronology and IMR Further information
Care Home B	Chronology Further information
Essex Adult Social Care and Safeguarding Adults Board	Information (contextual)
Essex Partnership University NHS Foundation Trust	Chronology and IMR
General Practice for Douglas	Chronology
Metropolitan Police Service	Chronology
North East London NHS Foundation Trust	Chronology and IMR

2.2. IMR authors were independent of the case and of line management of those involved with Mary or Douglas. This was with the exception of the General Practice and the Care Homes, all of which were too small for all staff to have been independent of the case. In these cases, the independent chair additionally scrutinised the information provided.

2.3. An IMR was requested from the General Practice; this was not provided. They submitted an outline of the contact they had, but no analysis or commentary on that contact or the Terms of Reference. As a result of this, the independent chair provided analysis within the Overview Report, and the General Practice commented on this.

3. The Workshop

3.1. Due to the DHR being delivered at Level 3 the independent chair gathered the available information from the relevant agencies and developed a multi-agency workshop from this information. Other DHRs and a thematic review completed in Essex, and other national reviews, were also used to inform the workshop.

3.2. The main focus for the workshop was: *how agencies engage families in the care of older people, those with care and support needs, and people with mental health care needs*. While there was no indication of prior abuse in this case, to ensure all learning was considered, the question 'what if there is domestic abuse? How is this identified and responded to?' was also included.

3.3. A series of exercises were held with the participants to identify the learning in relation to this theme. Participants were also asked to outline how they identify and respond to carers, and what this response looks like, for example in terms of carers' assessments and/or referring on to support services. In addition, participants were asked to review the timelines of agency contact for Mary and Douglas to identify good practice and comment on areas for learning. The outcomes are set out in section 10 below.

4. Review Chair and Author

4.1. The Chair of the DHR and report writer was Althea Cribb. Althea has been carrying out Domestic Homicide Reviews for five years and has completed sixteen DHRs to date. Althea has worked in the domestic abuse sector for twelve years in a range of roles including local authorities and charities, delivering front line and strategic partnership roles. Althea Cribb has no connection with the Epping Forest Community Safety Partnership.

5. Terms of Reference

5.1. Based on the information gathered during the setting up of the DHR, the following issues were identified as areas for the independent chair, involved agencies and the workshop attendees to consider:

- Protected characteristics / additional vulnerabilities of Mary: age; disability; mental health; vulnerable adult.
- Protected characteristics / additional vulnerabilities of Douglas: mental health.
- Safety of vulnerable adults residing in care homes.
- Engagement of Douglas in his mental health treatment and care.

5.2. Agencies completing IMRs will be required to analyse these issues in relation to their contact with Mary or Douglas, with specific reference to:

- What policies, procedures and guidelines provide the framework for the agency's response to the above issues.

- What training is available to, and accessed by, staff in relation to responding to the above issues.
- What communication should have taken place between agencies in relation to the above issues; whether this took place; the quality and outcomes of that communication.

6. About Mary

6.1. Mary was aged 94 when she died.
6.2. She had been a seamstress and dressmaker all of her working life.
6.3. She had two children, one of whom was still living.
6.4. She lived in a residential care home for people with Alzheimer's, and was visited regularly by her daughter who had been her carer.

7. About Douglas

7.1. Douglas was aged 32 at the time of the homicide, and was employed as a manual labourer. He lived with his mother (Mary's daughter) in the London Borough of Redbridge.
7.2. From July 2015 to the homicide Douglas had had sporadic contact with his General Practice and North East London NHS Foundation Trust (NELFT) with regard to his mental health, for which he was treated. He was referred to drug and alcohol services but this did not progress to service provision.

8. Conclusions

8.1. The process of the DHR was to address the case within a partnership workshop and discuss it in the context of similar cases and learning themes. The discussions were therefore wide ranging and looked at broad learning in addition to that identified in section above for specific agencies.
8.2. Six themes emerged from the multi-agency learning workshop, and the areas where lessons need to be learnt are detailed below.
1. Domestic abuse: enquiry, understanding and response
2. Think Family
3. Information sharing
4. Multi-agency working
5. Staff confidence
6. Carers

8.3. In relation to these themes, the good practice identified was: a county-wide information sharing protocol is in place; agencies are engaged with MARAC and MAPPA, and most use the DASH; a new website has been launched by the Southend Essex and Thurrock Domestic Abuse Board to raise awareness and to inform about services; Princess Alexandra Hospital (Harlow) practices routine enquiry within medical assessments, and the Daisy Maternity Project is in place to ensure women who disclose receive prompt support from an Independent Domestic Violence Advisor (IDVA). Safer Places, which provides IDVA services across Essex, also offers training to staff across the County.
8.4. The Southend Essex and Thurrock Domestic Abuse Board has a strategic multi-agency membership, which has developed a SET Domestic Abuse Strategy. The principles of the Strategy drive all domestic abuse work across SET. There are five overarching outcome themes, each of which has its own action plan:
- Outcome 1: Young people enjoy healthy relationships.
- Outcome 2: Victims (adults and children) and those at risk of experiencing domestic abuse are and feel safe.

- Outcome 3: Victims (adults and children) are able to recover and move on independently.
- Outcome 4: Perpetrators are prevented from causing physical and emotional harm.
- Outcome 5: Communication and professionals have a greater awareness of what an abusive relationship is and how to stay safe.

8.5. The SET Domestic Abuse Partnership governance structure also contains a Joint Commissioning Group to: encourage joint working; enhance multi-agency commissioning where possible; and where possible ensure consistency of services and delivery across Southend, Essex and Thurrock.

9. Lessons to be Learned

9.1. The lessons to be learned from the key themes listed above related primarily to information sharing and responses to carers.

9.2. Participants identified that staff sometimes do not have the confidence to undertake appropriate information sharing, and that when consent has not been sought from the service user, this can prevent them from sharing information. Information sharing across local authority borders was also identified as a challenge. A recommendation (1) is made for the Southend Essex and Thurrock Domestic Abuse Strategic Board to share the learning in relation to information sharing through its networks.

9.3. The conclusion from the workshop in relation to carers and families is that a better response, and support, is required for families who are supporting individuals with care and support needs, mental health issues or drug/alcohol issues:

- An improved culture of recognition is needed of the role of families, and of carers' needs and how agencies can respond to this.
- Better systems need to be in place to ensure staff have the tools and confidence they need to identify and support individuals, families and carers.
- Strategic and operational partnerships are in place and these can be promoted more widely to improve information sharing, communication, referrals and multi-agency working.

11.3 There was consensus that agencies need to consider the needs of their clients' families, and ensure that they are offered relevant support, which may or may not be through a carer's assessment. Recommendations are made to address this learning for the Essex Safeguarding Adults Board (2) and Essex Care Association (3).

10. Recommendations

NELFT Serious Incident Investigation Report recommendations:

12.1 Psychiatric Liaison Service and Access and Assessment Brief Intervention Team must be made aware that service users are taken on by Early Intervention in Psychosis Team for up to three years and can be referred back at any point during that time.

12.2 All Mental Health Service staff to continue to make attempts to obtain collaborative information and to indicate in progress notes the reason for not obtaining collaborative information from families and carers.

12.3 The findings of this investigation should be shared with the victim's next of kin and the service user. A meeting should be offered and facilitated by the Integrated Care Director if required, in order to discuss the findings. The investigation panel was unable to contact the service user due to the Criminal Justice process. Should the service user request a copy of the findings of the report at a later date; the Integrated Care Director should arrange to share the findings of the report.

Overview Report recommendations:

12.4 (1) The Southend Essex and Thurrock Domestic Abuse Strategic Board to continue to share learning from DHRs; in relation to this case to share the information sharing related learning from this case to all agencies, using existing networks, communication channels and events (e.g. flag through the Essex DHR Thematic Review highlight in training and cascade to other agencies). Specifically emphasising the need for agencies to ensure that staff to gain consent for information sharing (with other agencies and families) in their initial assessments with clients; and for agencies to ensure staff understand and feel confident about information sharing, in particular contacting other boroughs and areas.

12.5 (2) Essex Safeguarding Adults Board to: seek assurance from its partners that support is available to carers; and ensure that support for carers is integrated into its training, awareness raising and communications relating to safeguarding adults.

12.6 (3) Essex Care Association to promote the findings from this DHR amongst its members.

12.7 (4) A further recommendation is made for NELFT to communicate to all teams the correct referral pathways to the local drug and alcohol service.

11. Action Plan

Recommendation	Scope	Action to take	Lead Agency	Key milestones	Target Date	Completion Date and Outcome
The Southend Essex and Thurrock Domestic Abuse Strategic Board to continue to share learning from DHRs; in relation to this case, including the information sharing related learning to all agencies, using existing networks, communication channels and events (. Specifically emphasising the need for agencies to ensure that staff gain consent for information sharing (with other agencies and families) in their initial assessments with clients; and for agencies to ensure staff understand and feel confident about information sharing, in particular contacting other boroughs and areas.	County-wide	Dissemination of learning from this DHR across the partnerships. Cascade learning from the annual DHR Thematic Review to partners through SET DAB Seminars.	SET DA Central Team	Annual DHR Thematic Review and DHR seminars. Through DA training cascaded via agencies.	March 2020	Ongoing. Share learnings from domestic homicides. Raise confidence on identification and sharing of information on domestic abuse across partnerships. Raise awareness on specialist domestic abuse support services and resources that are available, via our SET DAB website.
Essex Safeguarding Adults Board to: seek assurance from its partners that support is available to carers; and ensure that support for carers is integrated into its training, awareness raising and communications relating to safeguarding adults.	County-wide	Thematic Board meeting to be held (July 2019) focussing on carers and seeking assurance from partners that support is available for carers Publicity campaign (November 2019) that will include raising awareness of safeguarding for carers.	ESAB	ESAB meeting 3 July 2019 Publicity campaign commencing 18 November 2019	December 2019	
Essex Care Association to promote the findings from this DHR amongst its members.	County-wide	Use of published reports and existing communication mechanisms to highlight learning.	Essex Care Association	Communication completed	December 2019	
Feedback from Redbridge outlined at paragraph 17.31 of the Overview Report to be fed back to NELFT and for this to be cascaded to all teams	Local	SET DA Team to communicate this to NELFT and ask what action will be taken in response to ensure the information is communicated to all teams.	SET DA Team	Contact with NELFT NELFT confirm actions taken	December 2019	