Executive Summary

DOMESTIC HOMICIDE REVIEW

in respect of

NATALIE KING

Born 1976
Deceased 11 December 2012
Black Caribbean

Chris Few
October 2013

INTRODUCTION

1.1 This Executive Summary relates to a Domestic Homicide Review[1] commissioned by the Daventry District and South Northamptonshire Community Safety Partnership on 3 January 2013 consequent to the death of Natalie King[2].

1.2 On 11 December 2012 Police and Ambulance Service staff attended the home address of Natalie King in response to a call from a neighbour. She was found to have sustained stab wounds from which she died in hospital a short time later.

1.3 Henry Davison, with whom Natalie King had commenced a relationship in 2006 and had two children, was arrested at the scene. In June 2013 Henry Davison was convicted of Natalie King's murder and sentenced to life imprisonment with a recommendation that he serve at least 16.5 years.

1.4 Prior to the death of Natalie King there was involvement with the family by the Police, primary health care services, Children's Social Care and specialist domestic abuse services directly in connection with domestic Abuse; as well as with the UK Border Agency, Action for Children, nurseries, a school, housing providers and midwifery / hospital services all of whom were to varying degrees aware of abuse within the relationship.

1.5 On four occasions specific incidents of domestic abuse were reported to the Police by Natalie King and consequently other agencies were engaged. An allegation was also made by Henry Davison that Natalie King had assaulted one of their children leading to further professional contact. Natalie King's situation was considered at a MARAC[3] on two occasions.

1.6 In general both adults tended to be fairly open about the presence of violence in their relationship but did not meaningfully engage with services. None of the reported incidents of violence led to the prosecution of Henry Davison.

1.7 The Review considered in detail the period between 1 January 2009, when the family moved to Northamptonshire, and 11 December 2012 inclusive. Summary information regarding significant events outside of this period was also considered.

1.8 Specific issues addressed by the review were:

- The way in which agencies worked together to identify concerns, share information and support victims of domestic abuse. Give a particular focus on the relationship between domestic abuse support services and MARAC
- What efforts were made by agencies to access information held by health service agencies in relation to both Natalie King's and Henry Davison's physical and mental health and how it may have impacted on Natalie King's ability to remain safe?
- What relevant historical information was known to the agencies prior to Natalie King's death about the background and experiences of Natalie King and Henry Davison? Was this information effectively shared to ensure that appropriate decisions could be made to ensure Natalie King and her children were protected from any known risks?

[1] Domestic Homicide Reviews were introduced by the Domestic Violence, Crime and Victims Act (2004), section 9. A duty on a relevant Community Safety Partnership to undertake Domestic Homicide Reviews, along with associated procedural requirements, was implemented by the *'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews'* on 13 April 2011. (Revised guidance has since been introduced for reviews commenced after 1.8.13).

[2] The names within this Review are pseudonyms used to protect the privacy of family members.

[3] Multi-Agency Risk Assessment Conference.

- Did the professionals working with Natalie King and her family have the required knowledge, skills and experience regarding the identification of and required response to possible domestic abuse? Were there any gaps in practice that may have impacted upon the outcomes for Natalie King?
- With hindsight what, if anything, could have been done differently and what impact, if any, such action may or may not have had on the outcomes for Natalie King? If so why wasn't that action taken?
- What consideration was there of their immigration status and the impact this status may have had on the family approaching services and conversely the response from agencies?
- Is there any evidence of a joined up approach between services focussed on adult needs and those focussed on children and families' needs.

1.9 The Review Panel was chaired by Martin Hammond, Deputy Chief Executive of Kettering Borough Council and Chair of Kettering Community Safety Partnership, under a reciprocal arrangement with Daventry District and South Northamptonshire Community Safety Partnership.

1.10 This report of the Review was written by Chris Few, an Independent Consultant.

1.11 The Review Panel, comprising representatives of the key Northamptonshire agencies involved with the family met on three occasions to consider contributions to and emerging findings of the Review:

- 5 July 2013
- 24 July 2013
- 21 October 2013.

1.12 The Overview Report was endorsed by the Review Panel consequent to their meeting on 21 October 2013 and forwarded to the Chair of the Daventry District and South Northamptonshire Community Safety Partnership. It was subsequently presented to and endorsed by the Community Safety Partnership.

1.13 Four relatives of Natalie King known to have had contact with her in the period under review, along with a friend with whom she was in close and regular contact, were invited to contribute to the Review. The report author and review coordinator consequently met with a brother, nephew, cousin and friend of Natalie King. These meetings provided valuable insight into both the life of Natalie King and Henry Davison as well as their perspective on information recorded and events known to professionals. The report author is extremely grateful for these contributions.

1.14 Henry Davison was contacted through HM Prison Service and interviewed in prison by the report author and review coordinator.

1.15 It is intended that the findings of this Review will be shared with family members as part of a communication strategy to be agreed by the Daventry District and South Northamptonshire Community Safety Partnership.

FINDINGS AND CONCLUSIONS

2 Predictability and Preventability

2.1 That Henry Davison and Natalie King had a turbulent relationship which included violence towards Natalie King was known to the majority of agencies involved with their family; and both individuals were in certain circumstances open about this. On four occasions Natalie King's situation was the subject of a formal DASH risk

assessment which indicated that she was at high risk of serious harm[4], albeit one assessment was subsequently re-evaluated to medium risk on the basis of Natalie King's perception of the relationship and the time elapsed since the last report of violence.

2.2 Risk of serious harm (which could include homicide) is not however a prediction that it will take place. Further, a large range of factors, many of which will change over time and be unknown to those using the risk assessment will impact on the dynamic risk level.

2.3 Natalie King's death, in December 2012, was some 17 months since the last contemporaneous report to professionals of violence in the relationship and 15 months since the last professional contact with the family, in September 2011, in relation to domestic abuse. In the interim references to domestic abuse by Henry Davison and Natalie King were of a historic nature and the agency in closest contact with the family, their daughter Harriet Davison-King's school, were not aware of current violence.

2.4 On this basis it would not have been reasonable for any professional to have predicted the murder of Natalie King from the information they had at that time.

2.5 The lack of predictability precludes the possibility of any professional or agency intervening to directly prevent the homicide.

2.6 With varying degrees of certainty the possibility of preventing Natalie King's murder could however have been incidental to more robust intervention and the provision of better services when agencies were in contact with the family.

2.7 The areas in which this may have been successful were:

- Detention and removal of Henry Davison from the UK as an illegal immigrant
- Prosecution, particularly if resulting in imprisonment, of Henry Davison for the criminal offences which he was alleged to have committed against Natalie King
- Persuasion of Natalie King to end her relationship with Henry Davison and supporting her to take effective action to protect herself
- Intervention with Henry Davison as a perpetrator of domestic abuse
- Child protection intervention in relation to the children of Henry Davison and Natalie King, which in addition to its inherent purpose, could have provided a formal robust mechanism for securing the cooperation of Henry Davison and Natalie King and incidentally led to continued professional involvement with the family in relation to violence beyond September 2011.

2.8 The following sections highlight key findings of the Review and areas in which better services should have been provided.

3 Immigration Status of Henry Davison

3.1 Although there is no guarantee that the detention of Henry Davison by the UK Border Agency would have led to his deportation (particularly taking into account that he had children in the UK) this was the intervention most likely to be successful in preventing the homicide of Natalie King by removing his access to her.

3.2 The only reasonable opportunity to achieve this was in 2011 when Henry Davison disclosed to a Social Worker that he was in the UK illegally. Reporting this admission to the UK Border Agency, or Police, would have placed them in a far stronger position

[4] Risk of serious harm is defined as a risk which is life threatening and / or traumatic, and from which recovery, whether physical or psychological, can be expected to be difficult or impossible.

to identify Henry Davison's real identity and respond accordingly than they had been able to do in 2009 when Henry Davison provided convincing documentation to the authorities in support of his assumed identity. The absence of clear guidance to Northamptonshire County Council staff on how to respond when an individual is identified as illegally in the UK contributed to this not taking place.

3.3 It is recommended that:

All agencies should ensure that they have in place clear and unequivocal guidance on the approach to be taken by staff when they identify or suspect that an individual is illegally in the UK.

4 Services for Victims of Domestic Abuse

4.1 The DASH risk assessment tool was not available or used by a range of professionals, primarily in health settings, who would have found this valuable in arriving at evidence based assessment of risk to Natalie King and her children.

4.2 There was a failure to record the disclosure by Natalie King that she had been raped by Henry Davison; an offence which information provided to the Review suggests was a serial feature of the domestic abuse. Consequently no investigative action was taken and no targeted support for this type of abuse was offered to Natalie King.

4.3 Northamptonshire Police have in place a comprehensive guide to the investigation of Domestic abuse which includes an imperative to gather evidence which may support a prosecution that is not dependent upon the victim. Investigation by Officers responding to reports of domestic abuse from Natalie King was not however compliant with this guidance. The standard of investigation and an apparent lack of cognisance that prosecution without evidence from the victim was a possibility were contributed to by a lack of specialist Domestic Abuse Unit capacity resulting in the investigations being undertaken by non-specialist response officers.

4.4 In conjunction with developments already being implemented the Police have made appropriate recommendations in respect of these issues.

4.5 The Panel was however informed that even in cases where a comprehensive investigation results in alternative evidence being obtained, this is in practice unlikely to be viewed by the Crown Prosecution Service as meeting the statutory threshold for prosecution in the absence of cooperation from the victim.

4.6 It is therefore recommended that:

The Community Safety Partnership Chair should write to the Crown Prosecution Service and seek assurance that wherever the evidence available in a domestic abuse case meets the statutory evidential test the presumption will be that prosecution is in the public interest, regardless of whether the victim is prepared to support that prosecution. Such assurance should be disseminated to all agencies and professionals involved in responding to domestic abuse.

4.7 Safety plans put in place by the Police were dependent upon Natalie King ending her relationship with Henry Davison and excluding him from her household and contact with their children. The Safety Plans were not re-visited by the Police, Sunflower Centre or at MARAC's when it became apparent that Natalie King was continuing her relationship with Henry Davison. They were regarded as a fixed entity rather than as a dynamic plan that should evolve as circumstances developed.

4.8 Provision of services by the Sunflower Centre operated as an overly permissive process and throughout the period under review Natalie King did not engage with

these services. It is a positive that IDVAs now take more proactive steps to encourage victims of domestic abuse to engage with them and accept support.

4.9 Screening of cases referred to MARAC was and remains in place with a threshold higher than that recommended by national guidance. In relation to the first domestic abuse incident reported to the Sunflower Centre the IDVA did not recognise that Natalie King's was a case in which professional discretion should be exercised. This delayed consideration of Natalie King's situation by a MARAC.

4.10 The two MARACs which considered Natalie King's situation were not effective in identifying the nature of risks or measures which may have protected Natalie King from further abuse. Further, the actions agreed by the MARACs were not implemented and systems did not provide a means of monitoring the progress with and impact of these.

4.11 MARAC procedures, with an overly restrictive focus on the current situation, acted as an artificial barrier to consideration of what interventions had and had not been effective previously.

4.12 Further issues regarding the engagement with MARAC of agencies providing services to children are outlined at section 5 below.

4.13 The Review was informed that an independent review of domestic abuse services, including MARAC, has been commissioned.

4.14 It is recommended that:

The Northamptonshire Community Safety Coordination Group should receive the report of the commissioned independent review of domestic abuse services, satisfy themselves regarding the effectiveness of MARAC arrangements taking into account national standards, and ensure that any deficits are addressed.

5 Coordination of Services for Victims of Domestic Abuse and their Children

5.1 There was little evidence of join up between services for victims and perpetrators of domestic abuse and services for their children.

5.2 Police Officers, when dealing with the domestic abuse incidents in this case, did not refer children exposed to such violence to Children's Social Care. They had discretion on whether to do this at that time although systems are now in place for all children in households where domestic abuse is reported to be referred to Children's Social Care and for managerial oversight of this. Notwithstanding this positive development the practice does indicate a lack of recognition of the impact that exposure to such violence may have, despite statutory recognition that this constitutes significant harm.

5.3 Sunflower Centre professionals and MARAC staff did not communicate effectively with those providing services to the children of Henry Davison and Natalie King. Reciprocally the response to domestic abuse in this case by those concerned with the children of Natalie King and Henry Davison reflected a wider lack of health service provider and Children's Social Care engagement with domestic violence services and MARAC arrangements. The situation in this regard is reported to have improved; although the framework for health service engagement is still evolving and the fragility of Children's Social Care commitment to MARAC appears to be a major constraining factor on MARACs being held as frequently as required to comply with national guidelines.

5.4 A recommendation in respect of MARAC arrangements is made at 4.14 above.

5.5 The Review was informed of practice in other areas of the country whereby referrals to Children's Social Care regarding exposure of children to domestic abuse are routinely copied to the family's Health Visitor or School Nurse, improving the ability of those professionals to offer a service that is responsive to this issue.

5.6 It is recommended that:

The MASH steering group build arrangements into relevant procedural pathways for the routine sharing of domestic abuse referrals to Children's Social Care with Health Visitors and/or School Nurse providing services to the children of the family.

5.7 Of particular concern is an evident underlying culture within agencies providing services for children in Northamptonshire of accepting and tolerating domestic abuse with this not being seen as part of their core business. This seems to incorporate the same lack of recognition that domestic abuse has a serious adverse impact on children demonstrated by Police practice in this case. This was discussed by the Panel and there was acknowledgement that this was part of the culture in Northamptonshire as recently as 2011. A view was expressed that things had improved significantly since these events and that there is now a cultural acceptance of the seriousness of domestic abuse. The introduction of and compliance with MASH pathways, new Police procedures and Children's Social Care service standards is reported to have led to routine referral and consideration of domestic abuse case. No evidence that this reflects an embedded cultural shift has however been presented to the Review.

5.8 It is therefore recommended that:

The Northamptonshire Community Safety Coordination Group should coordinate the development and implementation of an initiative to embed an appropriate culture and mind-set regarding domestic abuse across all agencies, along with measures to monitor the impact of this.

5.9 A more specific issue is the routine practice within Children's Social Care and the Sunflower Centre of sending unsolicited letters to parents of children referred to them as occurred in this case. This does not recognise that such communication, where domestic abuse is involved, may place the victim and children at greater risk. Alternative approaches to establishing contact are available and have been adopted by, for example, Women's Aid.

5.10 It is recommended that:

Agencies should consult those making referrals to them regarding safe methods of establishing contact with victims of domestic abuse consequent to referral of their children; and if necessary proactive personal contact should be made where the victim is away from the perpetrator. Consideration should be given to the risks to victims and their children prior to sending unsolicited letters.

6 Services for Children

6.1 Much of the practice in relation to safeguarding the children of Henry Davison and Natalie King did not comply with local procedures and statutory guidance, or represent good and effective practice.

6.2 The GP making a referral to Children Social Care in 2009 consequent ot disclosure by Natalie King of domestic abuse was in accordance with local child protection procedures although the referral itself demonstrated a lack of clarity regarding referral thresholds, processes and services. An Initial Assessment should have been conducted by Social Care in response to that referral, regardless of the view expressed by the GP that no action was needed.

6.3 Children's Social Care should have been more effective in their gathering of information to inform decisions on how cases should be progressed and assessments. In particular:

- Children's Social Care assessments did not take a holistic view of the family when identifying those professionals who should be asked to contribute and some key professionals were not engaged.
- Historic and background information regarding the effectiveness and degree of engagement by Henry Davison and Natalie King with services previously offered was not considered when planning Children's Social Care interventions.
- There was a lack of clarity about what was being sought in communication between Children's Social Care and other professionals, as a result of which key information was not provided.
- There was a failure to effectively engage Henry Davison in Children's Social Care assessments
- Information provided by Natalie King and Henry Davison to Social Workers undertaking assessments was not triangulated with other sources to establish its veracity.

6.4 There was a lack of recognition in a Children's Social Care assessment that Natalie King's pregnancy was likely to increase the risk of domestic abuse or contact with the Midwife.

6.5 Children's Social Care cases were closed or stepped down from the child protection framework prematurely and inappropriately, for example:

- Case closure was recorded before the assessment on which the closure decision was based had been completed
- Agreed actions were not implemented or completed before case closure.
- There were delays in management endorsement of Social Worker recommendations resulting delayed commissioning of services and in the family and professionals being left in limbo for an extended period.
- There was a lack of management challenge regarding completion of agreed actions.
- Child Protection Conferences were not convened in accordance with Child Protection procedures. This would have provided a formal multi-agency mechanism within which the risk of domestic abuse may have been addressed as part of a plan to protect the children.

6.6 Risk assessment information was not shared by Children's Social Care with Action for Children when a service was requested from that organisation.

6.7 Joint working between Children's Social Care and the Police was not effective.

- There was non-compliance with procedures for Children's Social care making a referral to the Police Child Abuse Investigation Unit and associated Police recording procedures.
- There was a lack of effective communication between Police and Children's Social Care professionals regarding the purpose and aims of a child protection assessment joint visit.
- Strategy discussions were not held as they should have been, undermining the coordination and effectiveness of responses and effective information sharing.

- There was a failure by a Police Officer to record an assault on a child and to investigate this in conjunction with Children's Social Care.

6.8 A Family Agreement was used by Children's Social Care which placed the onus for ensuring compliance on a victim of domestic abuse, without getting all parties to agree it and without any monitoring or review arrangements; thereby rendering it ineffective.

6.9 Housing Association and District Council staff accepted information from Natalie King that Children's Social Care were involved without confirming it and consequently assumed that referral of the children regarding their exposure to domestic abuse was not required.

6.10 Some of the above issues mirror the findings of recent Serious Case Reviews carried out in Northamptonshire[5] and many are reflected in the findings of a February 2013 Ofsted inspection of safeguarding services in Northamptonshire. A Children's Services Improvement Plan is in place to address the findings of that and earlier reviews and inspections. Further work, including planned multi-agency audit arrangements, will be required to establish the effectiveness of the improvement plan and its impact on services.

6.11 It is recommended that:

The Local Safeguarding Children Board Northamptonshire should consider the content of this Domestic Homicide Review report in conjunction with the current Children's Services Improvement Plan and identify what further action is required to ensure that arrangements for safeguarding children in the county are effective. This consideration should take a broad view across all partner agencies working with children and their families.

7 Services for Perpetrators of Domestic Abuse

7.1 Notwithstanding the possibility that Henry Davison may have been motivated by a wish to deflect culpability for his violence towards Natalie King, two occasions in 2009 when he sought assistance with management of his anger provided windows of opportunity to reduce the likelihood of subsequent violence.

7.2 The GP making referrals of Henry Davison to a Low Intensity Worker was appropriate; although the effectiveness of this may have been greater if more robust processes for making and monitoring referrals had been in place to ensure that Henry Davison was seen sooner and following the first referral.

7.3 When Henry Davison was seen by the Low Intensity Worker the basis for effective intervention was established but the plans for follow up came to nothing. Engagement in joint relationship counselling is alleged by Henry Davison to have not been pursued because Natalie King refused to participate. This did not however preclude provision of other services to help Henry Davison address his anger, potentially including referral to a more specialist practitioner.

7.4 It is unclear whether the range and capacity of services for perpetrators of domestic abuse and for relationship counselling in Northamptonshire was sufficient to address the needs of Henry Davison and other perpetrators of domestic abuse who seek help to address their behaviour. The Panel was informed of services for domestic abuse perpetrators currently being piloted in Northamptonshire.

7.5 It is however recommended that:

Northamptonshire Health and Wellbeing Board, in conjunction with all relevant commissioning bodies, and the Northamptonshire Police and Crime Commissioner

[5] For example reviews concerning Child JM/B (2010), Child F (2011) & Maisie (2013).

should consider the adequacy and effectiveness of services for relationship counselling and for perpetrators of domestic abuse in reducing the incidence of domestic abuse and ensure that any deficits are addressed.

8 Cultural Diversity

8.1 It is clear from the insight provided by members of Natalie King's family and social group, as well as from Henry Davison, that the cultural background of Natalie King and Henry Davison had a significant impact on their relationship, the parenting of their children and their attitude and response to professional intervention.

8.2 There is no indication from the information provided to the Review that this factor was considered by any of the professionals providing services to the family or responding to domestic abuse and child protection concerns. None of the contributions to the review explore this issue effectively or make recommendations in this regard.

8.3 It is therefore recommended that:

All agencies providing specialist services to victims and perpetrators of domestic abuse, and their families, should examine the effectiveness with which they respond to cultural diversity across their service delivery areas and report on this to the Northamptonshire Inter-Personal Violence Board.

RECOMMENDATIONS

9 The Review Panel made the following recommendations.

9.1 All agencies should ensure that they have in place clear and unequivocal guidance on the approach to be taken by staff when they identify or suspect that an individual is illegally in the UK.

9.2 The Community Safety Partnership Chair should write to the Crown Prosecution Service and seek assurance that wherever the evidence available in a domestic abuse case meets the statutory evidential test the presumption will be that prosecution is in the public interest, regardless of whether the victim is prepared to support that prosecution. Such assurance should be disseminated to all agencies and professionals involved in responding to domestic abuse.

9.3 The Northamptonshire Community Safety Coordination Group should receive the report of the commissioned independent review of domestic abuse services, satisfy themselves regarding the effectiveness of MARAC arrangements taking into account national standards, and ensure that any deficits are addressed.

9.4 The MASH steering group build arrangements into relevant procedural pathways for the routine sharing of domestic abuse referrals to Children's Social Care with Health Visitors and/or School Nurse providing services to the children of the family.

9.5 The Northamptonshire Community Safety Coordination Group should coordinate the development and implementation of an initiative to embed an appropriate culture and mind-set regarding domestic abuse across all agencies, along with measures to monitor the impact of this.

9.6 Agencies should consult those making referrals to them regarding safe methods of establishing contact with victims of domestic abuse consequent to referral of their children; and if necessary proactive personal contact should be made where the victim is away from the perpetrator. Consideration should be given to the risks to victims and their children prior to sending unsolicited letters.

9.7 The Local Safeguarding Children Board Northamptonshire should consider the content of this Domestic Homicide Review report in conjunction with the current Children's Services Improvement Plan and identify what further action is required to

ensure that arrangements for safeguarding children in the county are effective. This consideration should take a broad view across all partner agencies working with children and their families.

9.8 Northamptonshire Health and Wellbeing Board, in conjunction with all relevant commissioning bodies, and the Northamptonshire Police and Crime Commissioner should consider the adequacy and effectiveness of services for relationship counselling and for perpetrators of domestic abuse in reducing the incidence of domestic abuse and ensure that any deficits are addressed.

9.9 All agencies providing specialist services to victims and perpetrators of domestic abuse, and their families, should examine the effectiveness with which they respond to cultural diversity across their service delivery areas and report on this to the Northamptonshire Inter-Personal Violence Board.

9.10 Recommendations for action to improve their services were also made by the following agencies which contributed to this Review:

- Action for Children
- Northamptonshire County Council Children's Social Care
- Northamptonshire Police
- NHS Corby and NHS Nene Clinical Commissioning Groups
- NHS England
- Daventry and District Housing Association
- Northamptonshire Healthcare NHS Foundation Trust.

9.11 Implementation of action plans arising from recommendations of the Review Panel and the contributing agencies will be monitored under arrangements to be agreed by the Daventry District and South Northamptonshire Community Safety Partnership.