Domestic Homicide Review Report

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

This Overview Report has been compiled as follows:

Section 1 will begin with an **introduction to the circumstances** that led to the commission of this Review and the process and timescales of the review.

Section 2 of this report will **set out the facts** in this case **including a chronology** to assist the reader in understanding how events unfolded that led to Karen's death.

Section 3 will provide **overview and analysis of the information** known to family, friends, employers, statutory and voluntary organisations and others who held relevant information.

Section 4 will address **other issues** considered by this Review

Section 5 will provide the **conclusion** debated by the Panel and will consolidate **lessons learned and the recommendations that arise.**

Appendix One provides the **terms of reference** against which the panel operated

Where the review has identified that an opportunity to intervene has been missed, this has been noted in a text box.

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.

This review has been undertaken in an open and constructive manner with all the agencies, both voluntary and statutory, engaging positively. This has ensured that we have been able to consider the circumstances of this incident in a meaningful way and address with candour the issues that it has raised.

The review was commissioned by Mansfield's Community Partnership on receiving notification of the death of Karen in circumstances which appeared to meet the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004.

Glossary

DASH	Domestic Abuse, Stalking and Honour based violence risk assessment model introduced to all UK police forces since 2009
DHR	Domestic Homicide Review
IMR	Individual Management Review – this is a review undertaken by an organisation to look at their interaction with the victim or perpetrator and identify good practice or lessons learned

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Section One – Introduction

1.1 Summary of circumstances leading to the Review

1.1.1 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.

1.1.2 The perpetrator was located the next evening at a local address following information given to the police.

1.1.3 The pathologist concluded that Karen had died as a result of manual strangulation.

1.1.4 The perpetrator was found guilty of murder and sentenced to life imprisonment with a minimum term of 16 years.

1.1.5 This is a case where the remarks of the sentencing Judge are relevant and help to further explain the behaviour of the perpetrator. He said the following:

"In the course of or after an argument you strangled her with your bare hands. You had admitted killing her unlawfully, but denied the intent required for the offence of murder. You had pleaded guilty to her manslaughter. The jury were clearly satisfied that you had the necessary intent for you to have committed the full offence.

As a result of what you did her family have lost a woman they loved. I have heard and read the personal statements written by two of her sisters. Her son has lost his mother. The effect of her death upon them is all too plain.

Having killed her, the only assistance you sought was for yourself. You never called the emergency services. Instead you went with a friend to buy drugs. You then tried to get friends to provide you with money and accommodation so that you could escape the consequences of what you had done. You were arrested some three days later.

When you were interviewed you made no mention of the fact that you had put your hands around her throat. You tried to make out that she had attacked you and that in the course of restraining her you had accidentally caused her death. You told the jury that you only remembered putting your hands around her neck when you read the pathologist's report, which gave the cause of death as manual strangulation. I am quite satisfied that you knew all along what you had done and only admitted it when you were confronted by the medical evidence".

It is within this context that this Review is set.

1.1.6 Following the conclusion of the criminal process, the coroner did not reopen the inquest.

1.2 Reasons for conducting the review

1.2.1 This Domestic Homicide Review is carried out in accordance with the statutory requirement set out in Section 9 of the Domestic Violence, Crime and Victims Act 2004.

1.2.2 The review must, according to the Act, be a review 'of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

(a) A person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) A member of the same household as himself, held with a view to identifying the lessons to be learnt from the death'.

1.2.3 In this case, the perpetrator has been found guilty of the murder of Karen. Therefore, the criteria have been met.

1.2.4 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

1.3 Process and timescales for the review

1.3.1 Mansfield Community Partnership were notified on 1st February 2018.

1.3.2 A partnership meeting was held on 19th February 2018 after an initial trawl had been undertaken to ascertain those agencies with knowledge of the victim and perpetrator. This meeting was chaired by the Chair of the Partnership and the decision was taken to appoint an independent chair and report author and proceed with a domestic homicide review.

1.3.3 The Independent Chair and Report Author were appointed in March 2018.

1.3.4 The Home Office were notified of the decision to carry out a DHR on 14th March 2018. The family were notified of the intention to hold a review.

1.3.5 The first panel meeting was held on 4th June 2018. The following agencies were represented at this meeting:

- CGL
- Equation
- Mansfield District Council

- Nottinghamshire Independent Domestic Abuse Services (NIDAS)
- Nottinghamshire Healthcare Trust
- Nottinghamshire Police
- Nottinghamshire Women's Aid
- Sherwood Forest Hospitals Trust (SFHT)

Apologies were received from Nottinghamshire County Council and DLNR Community Rehabilitation Company.

1.3.6 At this first meeting, the panel considered its composition and agreed that it brought together the relevant expertise in relation to the circumstances of this case. However, it was evident that the victim had been resident, in the past, in another area and so contact was made with the Community Safety Partnership there.

1.3.7 The panel met again on 13th November 2018 by which time it had been established that there was no information in the other area that was pertinent to the review. The panel considered IMRs from:

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

1.3.8 The panel met for a further meeting and the review was concluded in April 2019.

1.4 Confidentiality

1.4.1 The content and findings of this Review are held to be confidential, with information available only to those participating officers and professionals and, where necessary, their appropriate organisational management. It will remain confidential until such time as the review has been approved for publication by the Home Office Quality Assurance Panel.

1.4.2 To protect the identity of the deceased, their family and friends, Karen will be used as a pseudonym to identify the deceased hereafter and throughout this report. The person who murdered her will be referred to as the perpetrator.

1.5 Dissemination

1.5.1 The following individuals/organisations will receive copies of this report:

- Karen's family
- Chair, Nottinghamshire Health and Wellbeing Board
- Chief Constable, Nottinghamshire Police
- Chief Executive Officer, Mansfield and Ashfield Clinical Commissioning Group
- Chief Executive Officer, Nottinghamshire Women's Aid
- Chief Executive, Mansfield District Council
- GP practice for Karen
- Independent Chair, Nottinghamshire Safeguarding Adults Board

- Nottinghamshire Police and Crime Commissioner
- Senior Coroner for Nottinghamshire

1.6 Methodology

1.6.1 Mansfield Community Partnership was advised of the death by Nottinghamshire Police three days after the death. This was a timely notification and demonstrated a good understanding by the police of the need for a referral at the earliest opportunity.

1.6.2 In response to the notification, a partnership meeting was held on 19th February 2018. This was chaired by the Chair of the Community Safety Partnership. At this meeting, the police provided a summary of incident and those partners present shared the initial information that they held in relation to Karen and the perpetrator. At this meeting it was clear that agencies held very little information about this couple.

1.6.3 Having heard the contributions from the partners present, the Chair took the decision to hold the Domestic Homicide Review because it was clear that, given the information available at the time, there would be learning from this case. The Home Office was informed of the decision to undertake the review on 14th March 2018. This decision demonstrates a good understanding by the Chair of the Partnership of the issues surrounding domestic abuse and a willingness to welcome external scrutiny of the case in order that lessons could be learnt.

1.6.4 Gary Goose and Christine Graham were appointed in March 2018 to undertake the review and the Review Panel met for the first time on 4th June 2018. The Panel met three times and the final meeting of the Panel was in April 2019.

1.6.5 At the meeting on 4th June 2018 all members of the panel were present with apologies from the DLNR Community Rehabilitation Company and Nottinghamshire County Council. At this meeting, the process of the Domestic Homicide Review was explained to the panel with the Chair stressing that the purpose of the review is not to blame agencies or individuals but to look at what lessons could be learned for the future. Prior to this meeting, the Chair had met with the police's senior investigating officer (SIO) to ensure that Section 9 of the statutory guidance was adhered to. It was agreed that the review would proceed in limited scope until the criminal process concluded.

1.6.6 Agencies were asked to secure and preserve any written records that they had pertaining to the case. Agencies were reminded that information from records used in this review were examined in the public interest and under Section 115 of the Crime and Disorder Act 1998 which allows relevant authorities to share information where necessary and relevant for the purposes of the Act, namely the prevention of crime. In addition, Section 29 of the Data Protection Act 1998 enables information to be shared if it is necessary for the prevention and detection of crime, or the apprehension and prosecution of offenders. The purpose of the Domestic Homicide Review is to prevent a similar crime.

1.6.7 At this meeting the Terms of Reference were agreed subject to the family being consulted. It was agreed that the Chair and Overview Report author would make contact with the family.

1.6.8 Letters were sent to Karen's father and step-mother, two sisters and adult son ahead of the trial to introduce the review and make them aware of the support that was available through

AAFDA (Advocacy After Fatal Domestic Abuse) to help them through the review process. Following the trial, a further letter was sent to all parties. When no response was received, the report author met with the Police Family Liaison Officer (FLO) to discuss the review and the integral role that the family could play in the review. The FLO subsequently met with the family members to discuss this with them further. Unfortunately, the family felt that engaging would open up the circumstances again. The review fully understands and respects the family's position.

1.6.9 As the perpetrator's previous partner had given evidence in court, she was contacted with a view to her contributing to the review. It was felt that she could provide insight into the perpetrator's previous abuse. Unfortunately, she did not respond to the contact and the review respects her wishes.

1.6.10 The panel discussed whether the perpetrator should be invited to contribute to the review. On balance it was felt that this was not appropriate for this Review for two reasons. Firstly, the court determined that he had lied about the circumstances of the death and had attempted to escape the consequences of his actions; little would be gained by hearing those same lies again. Secondly, it was strongly felt that he should not be given more of a voice than Karen and that, in the circumstances of this case, the review could achieve its aims without his engagement.

1.6.11 As there was a criminal process, the review could only proceed in limited scope until this was completed. This delayed the completion of the report beyond the six months set out in the statutory guidance.

1.7 Contributors to the review

1.7.1 Those contributing to the review do so under Section 2(4) of the statutory guidance for the conduct of DHRs and it is the duty of any person or body participating in the review to have regard for the guidance.

1.7.2 All Panel meetings include specific reference to the statutory guidance as the overriding source of reference for the review. Any individual interviewed by the Chair or Report Author, or other body with whom they sought to consult, were made aware of the aims of the Domestic Homicide Review and referenced the statutory guidance.

1.7.3 However, it should be noted that whilst a person or body can be directed to participate, the Chair and the DHR Review Panel do not have the power or legal sanction to compel their co-operation either by attendance at the panel or meeting for an interview.

1.7.4 The following agencies contributed to the review:

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

- Nottinghamshire Women's Aid
- SFHT

1.8 Review Panel

1.8.1 The members of the Review Panel were:

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

1.9 Domestic Homicide Review Chair and Overview Report Author

1.9.1 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.

1.9.2 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.

1.9.3 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.

1.9.4 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.[1]

1.9.5 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)

1.10 Parallel Reviews

1.10.1 The coroner opened and adjourned the inquest until after the completion of the criminal process. Once this had concluded, the coroner did not reopen the inquest.

1.11 Equality and Diversity

1.11.1 Throughout this review process the Panel has considered the issues of equality in particular the nine protective characteristics under the Equality Act 2010. These are:

- Age
- Disability
- Gender reassignment

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

- Marriage or civil partnership (in employment only)
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

1.11.2 Women's Aid state '*domestic abuse perpetrated by men against women is a distinct phenomenon rooted in women's unequal status in society and oppressive social constructions of gender and family*'.[2] Women are more likely than men to be killed by partners/ex-partners. In 2013/14, this was 46% of female homicide victims killed by a partner or ex-partner, compared with 7% of male victims.[3]

1.11.3 The review is also mindful of the fact that it appears, from the limited information available, that Karen had a number of issues that increased her vulnerability. The CCG record in their IMR that her mental health state combined with chronic long-standing health problems made her vulnerable. Karen was not formally identified within services as 'vulnerable' and the level of this vulnerability and the impact that it had on her day to day life, has not been able to be verified with her family. Therefore, the review will consider these vulnerabilities in its analysis.

2 (Women's Aid Domestic abuse is a gendered crime, n.d.)

3 (Office for National Statistics, Crime Statistics, Focus on Violent Crime and Sexual Offences, 2013/14 Chapter 2: Violent Crime and Sexual Offences – Homicide, n.d.)

Section Two – The Facts

2.1 Introduction

2.1.1 Karen was a white British woman who was 44 years old at the time of her death. She has three sisters and a son of 28 years old from her previous marriage. She has a father and step-mother, her mother having died some years previously.

2.1.2 There was no evidence revealed by the police investigation to suggest that Karen had previously reported domestic abuse within her relationship with this perpetrator. There has been information provided to the review to suggest that Karen was involved in a volatile relationship in the past which may have included minor levels of physical violence by both parties.

2.1.3 The perpetrator was 39 years old at the time of the incident. He has a history of criminality, including 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.

2.1.4 A full chronology of events and a summary of information known by family, friends and agencies will follow within this report.

2.2 Detailed chronology

2.2.1 **Background information**

2.2.2 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.

2.2.3 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.

2.2.4 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.

2.2.5 The perpetrator has two children from previous relationships, with whom he has limited contact and Karen has an adult son from her previous marriage.

2.2.6 Detailed chronology from August 2017

2.2.7 On 28th August 2017 Karen moved to a property in Mansfield and applied for housing benefit. In her application she said that this was a bedsit in shared accommodation.

2.2.8 The perpetrator visited his GP on 1st September 2017, and it was recorded that he had mental and behavioural disorders due to opiate dependence syndrome (amphetamine and cocaine use). He had been involved in drug and alcohol services over a long period of time and a letter was written on this day to Change, Grow, Live (CGL).

2.2.9 On 5th September Karen was granted housing benefit.

2.2.10 Karen registered with a GP local to her new address on 15th September 2017.

2.2.11 On 20th September the perpetrator attended the GP surgery for a prescription. The GP noted that he was on the highest dose of medication for the pain that he experienced in his legs as well as a reducing methadone dose. The GP recorded that he looked well and maintained good eye contact. They discussed him reducing his dose of pain relief, but the perpetrator was not keen to do this whilst he was reducing his methadone dose.

2.2.12 Karen attended her GP on 13 November 2017 for a new patient registration check, having not attended three previous appointments. She was noted to be anxious and shaking during the appointment. She reported that she had long standing depression and anxiety. She reported that she lived alone, but in a shared house and had some support from her sister who lived nearby. She was given referral details for talking therapies and a further sick note.

2.2.13 When the perpetrator attended his GP on 13th November 2017 it was documented that he was on alcohol detoxification and a reducing dose of methadone. He reported that he was struggling but overall was managing to cope. He was provided with a sick note to state that he was not fit to work.

2.2.14 On 27th November 2017 Karen made a Homefinder application for social housing. On this application she stated that she was living alone in privately rented accommodation. She did not give any specific reasons for wanting to move but disclosed that she was suffering from agoraphobia, severe anxiety, manic depression and that she found it difficult to engage in social contact face to face or by the telephone. No domestic abuse was disclosed, and she requested help to bid on properties. She was given a band 3 classification as she had no settled accommodation.

2.2.15 The perpetrator was last seen by CGL on 27th November 2017.

2.2.16 Mansfield District Council wrote to Karen on 28th November 2017 to advise her of the banding that she had been given in respect of her housing application. She was told how she could appeal that banding, but no appeal was made.

2.2.17 In the period from 27th November 2017 to 8th January 2018 Karen submitted bids for seven different properties, all of which were unsuccessful.

2.2.18 On 6th December 2017 the perpetrator visited his GP and he began a nine-week switch from methadone to buprenorphine and a further sick note was provided.

2.2.19 The perpetrator attended the GP on 27th December 2017 and was given three months' supply of medication for his leg pain.

2.2.20 On 9th January 2018 the perpetrator attended the GP for a sick note and reported that he was now off methadone and on Subutex. He felt that he was doing well.

2.2.21 In January 2018 Karen and the perpetrator both moved to the address where the incident occurred. This was private rented accommodation with separate rooms for tenants but with shared communal areas. It appears that they moved together as a couple but maintained that they were single for the purposes of their benefit applications.

2.2.22 On 24th January 2018 the perpetrator's housing benefit was suspended due to a change in circumstances, his Jobseeker's Allowance having ended on 11th January 2018 because he was not fit for work.

2.2.23 Karen was last seen alive by one of the other residents in the house at mid-day on 28th January 2018 by a neighbour who said that he saw the perpetrator and the victim through the window. He described the perpetrator's behaviour as aggressive. He said he saw the perpetrator walking forward quickly into the room with his arms outstretched in what he interpreted as an aggressive pose.

2.2.24 During the morning of the 29th January 2018 the perpetrator contacted his former partner by Facebook messenger saying that that he needed to talk to her. They then exchanged a number of text messages in which the perpetrator said, 'She's dead. Please don't say anything.' 'Beg you not to say anything. Delete my text and I will ring you in 5'. His former partner then rang him, and he said, 'she's dead I am going to go back and clean up, then move her and report her missing in a couple of days'. He also said, 'I've ruined my life; I'm going to jail for life'. He then said, 'I rolled over and accidentally strangled her before I passed out'.

2.2.25 The former partner then contacted the landlord of the house as she was concerned about Karen.

2.2.26 At 6.22 pm the perpetrator sent a text to a friend saying, 'I need a massive favour. I am wanted for murder. Need some money to get away. You can have a Samsung galaxy s5 mini and my car for £50'.

2.2.27 It appears that he then took Karen's car that was parked outside the flats and used her bank card a number of times that evening.

2.2.28 On 30th January 2018 the perpetrator was located at a property in the area following information being given to the police. He was arrested and, following a series of no comment interviews, he produced a prepared written statement. In this statement he said that Karen regularly failed to take her medication and she would lose control and lash out. He said that during the evening they had an argument over something trivial and he began struggling with her. They both fell to the floor and he was trying to calm her down. He said he applied his weight onto her to keep still. He said that he got off her after a few minutes and realised what had happened. He claimed he had no intention to hurt or kill her.

2.2.29 He was charged with Karen's murder. When he was arrested, the perpetrator tested positive for Cat A drugs.

2.2.30 The perpetrator pleaded guilty to manslaughter but was found guilty of murder[4].

2.2.31 The perpetrator was sentenced to life imprisonment with a minimum term of 16 years.

[4] Refer back to Section 1 1.4 for details of the sentencing remarks

Section 3 – Detailed analysis of agency involvement

The chronology sets out in Section 2 details about the information known to agencies involved. This section summarises the totality of the information known to agencies and others involved during the years leading up to the incident. The detailed chronology will not be repeated here; rather this section will provide an analysis of agency involvement.

3.1.1 Nottinghamshire Police

3.1.1.1 Karen had three historic criminal convictions. The earliest was in 1992 and the last in 2008.

3.1.1.2 The perpetrator has numerous convictions dating back to 1995. His last conviction was in July 2010. He was convicted on 17 separate occasions for a total of 78 offences. The majority of these offences relate to offences of dishonesty, fraud, drug offences and driving whilst disqualified. He has no convictions involving domestic abuse.

3.1.1.3 Prior to the incident the police had no joint involvement with Karen or the perpetrator. There had been no calls to them about domestic abuse between them.

The review is satisfied that, whilst some systemic recommendations may arise within this Review, there is are no specific aspects of learning for the organisation.

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

3.1.2.1 **Karen**

3.1.2.2 Karen was registered with a GP in Mansfield at the time of her death and her medical records were flagged with a number of alerts which included physical healthcare problems and alerts for severe anxiety and a long-standing depressive illness. One of the physical issues that she suffered with was chronic obstructive pulmonary disease that had an impact on her everyday life.

3.1.2.3 Karen had a history of non-attendance at appointments, which were compensated for somewhat by telephone contact wherever possible by the GP. She had ongoing agoraphobia and claimed to go for significant periods without leaving the house.

3.1.2.4 There were a number of contacts with the GP that are out of the scope of this review but some significant contacts as below:

- In February 2015 she reported thoughts of self-harm and depression although had no plans to implement these thoughts. She claimed to have no friends and family locally. She was given details of local services and how to access the crisis support team.
- In December 2016 she had a telephone consultation with the GP to review her medication and claimed to have not left the house since November 2015.
- In May 2016 Karen had a telephone consultation with the GP and reported that she continued to feel anxious. She was waiting for an appointment for Cognitive Behaviour Therapy. She said that she had friends who did her shopping and that it could take her days to motivate herself to leave the house.

3.1.2.5 On 13th November 2017 she attended the GP surgery for a new patient registration check. This was following three non-attendances at appointments. She was anxious and shaking during the contact. It was recorded that she had long-standing depression and anxiety. She

said that she lived in a shared house, but on her own. She said she had some support from her sister who lived nearby. She was given details of talking therapy.

3.1.2.6 The CCG record in their IMR that her mental health state combined with chronic long-standing health problems made her vulnerable. Although she appeared to have friends and family support since moving to the area there continued to be protracted periods of agoraphobia and anxiety.

3.1.2.7 There is no record in the GP records of any signs or disclosures of domestic abuse and it does not appear that the cause of her long-standing anxiety was established.

3.1.2.8 Karen was not registered at the same practice as the perpetrator so the link between them (of the same address) was not made.

The review agrees with the CCG that Karen presented with general health problems and was provided with support for her mental health issues. Clinical support appears to have been provided appropriately and there were no disclosures of domestic abuse with the consultation process. However, given the fact that consultations were conducted over the telephone due to her agoraphobia, it would have been proactive to see that the GP asked her an open question such as, 'and how are things at home?' which would have given the opportunity to disclose any domestic abuse.

Recommendation

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).

3.1.2.9 **The perpetrator**

3.1.2.10 The perpetrator had been registered with a GP practice in Mansfield since December 2016. The previous GP practice did not use the SystmOne and therefore the detail within the records prior to this date was limited.

3.1.2.11 The perpetrator had a code on his records for heroin dependence. The last letter on the file regarding this dependence was dated 1st September 2017 and records mental and behavioural disorders due to opiate dependence syndrome (amphetamine and cocaine use). There appears to have been a long involvement with drug and alcohol services. He had been admitted to a residential drug treatment service in 2016 but GP consultations for this time are not available.

3.1.2.12 There was no indication in the notes that the perpetrator was in a relationship with Karen.

3.1.2.13 The perpetrator was on a regular prescription for Gabapentin which appears to have been prescribed for leg pain due to leg ulcers.

3.1.2.14 On 24th January 2017 the perpetrator was seen by the nurse requesting a prescription for Gabapentin. Reducing the dose was discussed with him and it was noted that he was on a reducing dose of methadone.

3.1.2.15 On 12th May 2017 he was seen to discuss reducing the dose of Gabapentin, but he reported that the pain in his legs was getting worse since he had begun reducing his methadone and Gabapentin. He reported that he had been injecting again in the last month due to the pain.

It was agreed to authorise his prescription for a further three months when it would be reviewed again.

3.1.2.16 When he was seen on 13th November 2017, the perpetrator reported that he was on alcohol detoxification and methadone reducing dose. He said that he was struggling to cope but overall, he was managing. He was given a sick note stating he was not fit to work.

3.1.2.17 On 6th December 2017 he saw the GP and reported that he was starting a nine-week switch from methadone to Buprenorphine. He was given a further sick note for four weeks.

3.1.2.18 On 27th December 2017 his prescription for Gabapentin was re-authorised for 3 months whilst he was trying to wean off methadone.

3.1.2.19 The perpetrator attended the GP on 9th January 2018 and reported that he was now off methadone and on Subutex and felt he was doing very well.

The review agrees with the CCG that the perpetrator presented as a single man and was offered appropriate clinical support. The GP was not aware of any risks in relation to domestic abuse. There are no specific recommendations identified for the GP practice.

3.1.3 Nottinghamshire Healthcare NHS Foundation Trust

3.1.3.1 Other than a referral to the Adult Mental Health Team in 2004 when she moved to the area, which Karen did not take up, Karen was not known to the service.

3.1.3.2 The service had no recent contact with the perpetrator until he was seen in custody after his arrest on 31st January 2018. There were no mental health issues identified at this time.

The review is satisfied that, given the limited interaction with the couple, there is no specific learning for the organisation.

3.1.4 Change, Grow, Live (CGL)

3.1.4.1 The perpetrator was known to have an addiction to heroin, and he received treatment over the period of the review. He regularly received a prescription for methadone, a heroin replacement from CGL. From October 2014 he saw CGL regularly from October 2014 to the date of the incident.

3.1.4.2 In October 2014 he was using heroin as well as his prescription medication. In November 2014 he discussed with CGL the possibility of going to in-patient detox. In March 2015 it was agreed that he was suitable, and it was agreed to increase his methadone and that he would no longer use heroin. On 8th July 2015 he was advised that a place would become available for him in 4-5 weeks' time. When he was offered a place at in-patient detox on August, he declined this as he felt the timing was not right as he had some work that would help him reduce his rent arrears. He continued to be prescribed methadone and use heroin and requested another date to go to in-patient detoxification.

3.1.4.3 In January 2016 the perpetrator was offered a place at in-patient detoxification which he attended between 20th January and 3rd February. He then continued on his methadone prescription before returning to the in-patient detoxification on 16th February. On 7th March he was discharged from the in-patient detoxification substance free and prescription free.

3.1.4.4 The perpetrator continued to engage regularly with CGL and was substance free for six weeks. He was prescribed methadone on 28th April 2016. He was reported to be disappointed with himself. By the end of June, he was providing clear urine samples (with the exception of methadone).

3.1.4.5 At the end of November he tested positive for methadone and cocaine. This was one test and he then returned to having tests that were clear for all substances except methadone and he began to talk about reducing his methadone dose.

3.1.4.6 On 1st June 2017 CGL recorded that his last structured one to one had been in January 2017 and his last medical review had been in December 2016. He was then seen on 24th August. At this appointment he reported that he was using amphetamine but no other substances other than methadone. At a medical review on 1st September he reported that he was then using cocaine as well. At this meeting it was agreed that he would reduce his methadone script.

3.1.4.7 On 11th December 2017 the perpetrator switched from methadone to buprenorphine. On 22nd December he contacted CGL to say that he was struggling with the buprenorphine and enquired about the dose being increased. This was actioned on 6th January 2018.

The review is satisfied that over the course of his engagement with CGL, the perpetrator was supported to reduce his substance misuse. There are no specific recommendations for this organisation.

3.1.4 Mansfield District Council

3.1.4.1 **Karen**

3.1.4.2 Karen first made contact with the Homelessness Team in September 2009 when she held a tenancy with Chesterfield Borough Council. She was seeking help in securing a property in Mansfield as she needed to flee Chesterfield due to violence from the wife of a man she was in a relationship with. She was advised that, as she had a tenancy in Chesterfield, and it was reasonable for her to return to that property, she did not meet the criteria.

3.1.4.3 On 28th August 2017 Karen moved to an address in Mansfield. This was a property with a number of bedsits in shared accommodation. The perpetrator was already living at this property, having moved there in November 2016. Her housing benefit application, as a single person, was awarded on 5th September 2017.

3.1.4.4 On 23rd November 2017 she made a Homefinder application (for social housing). This was in her name only. She gave no reasons for wanting to move but did disclose that she was suffering from agoraphobia, severe anxiety, manic depression and found it difficult to engage in social contact face to face and by telephone. No domestic abuse was disclosed on this application. She was awarded band 3[5] as she had no settled accommodation. She was advised that she could appeal against this banding, but no appeal was made.

3.1.4.5 Between 27th December 2017 and 8th January 2018 Karen submitted bids for seven different properties but was not successful.

[5] Applicants will be banded according to their priority with Band 1 being the highest and Band 5 being the lowest

3.1.4.6 The interactions with Karen by the Homelessness Team were in line with policies and procedures at the time. It is noted that, given the changes brought in by the Homelessness Reduction Act there are now additional duties for the council to prevent and relieve homelessness.

The review is satisfied that as Karen had, on two previous occasions outside the scope of this review, approached the council when she was fleeing domestic abuse and had been supported by them with temporary accommodation and advice, she recognised the council as a source of support.

3.1.4.7 **The perpetrator**

3.1.4.8 On 16th November 2016 the perpetrator made a Homefinder application for himself and his daughter.[6] He disclosed on the application form that he was of no fixed abode and a previous criminal conviction. This meant that he was ineligible for Homefinder.

3.1.4.9 He made an application for housing benefit in respect of the property in Mansfield as a single person. He received housing benefit until 24th January 2018 when this was suspended due to a change in circumstances, his Jobseeker's Allowance having ended on 11th January 2018 because he was not fit for work.

3.1.4.10 The interactions with the perpetrator by the Homelessness Team were in line with the policies and procedures at that time.

The review notes that there are no housing benefit records to indicate that Karen or the perpetrator had advised them that they were a couple or that there was any association between them. There are no records to indicate that they had advised the council of their move to the new property shortly before the incident.

There are no specific recommendations for Mansfield District Council.

[6] The review is satisfied that he did not have overnight contact with his daughter

Section Four – Analysis

4.1. 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.

4.2 The living arrangements were such that they each had a tenancy for a single room. The tenants shared the kitchen and bathroom facilities. We know that the landlord knew them to be a couple because, when he had refurbished the property in which the incident occurred, he offered them to move there as they were good tenants. Again, they each had a tenancy for a single room and shared a kitchen.

4.3 Mansfield District Council were not aware that they were a couple, both were claiming housing benefit as a single person.

4.4 Both Karen and the perpetrator had limited contact with agencies and none of those that they did have contact with had no knowledge that they were in a relationship.

4.5 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[7].

4.6 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.

4.7 It does not appear, from the information that we have, that Karen had a large network of friends. We believe that her sister would visit to assist with shopping, but she appears to have been very isolated. This would have led to her being more reliant on the perpetrator not only for emotional support but also for help with everyday tasks.

4.8 We know that, on two occasions in the past, Karen had sought help from the council because she was fleeing domestic abuse, so we can surmise that she knew that they were an agency that could help her in these circumstances. However, she did not disclose to them, or any other professional, that she was experiencing domestic abuse. We know that she was isolated and dependent upon the perpetrator because she was unable to leave the house without difficulty due to the agoraphobia that she experienced. This may have left her feeling unable to seek help from the agencies that had helped in the past.

4.9 We do not know the circumstances of the fraudulent claim for housing benefit. It might be that they did not realise that they were claiming more housing benefit, as single people, than they would have been entitled to as a couple. If this deception was deliberate, then we do not know how complicit Karen was in this. We do not know if she was coerced by the perpetrator into this course of action.

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

4.10 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[8].

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

Section Five - Conclusions

5.1 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.

5.2 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.

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

Section Six – 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).

Appendix One - Terms of reference

OPERATION HASLOCK
Terms of Reference for the Domestic Homicide Review into the death of Karen

1 Introduction

1.1 This Domestic Homicide Review (DHR) is commissioned by Mansfield Community Partnership in response to the death of Karen which occurred in January 2018.

5.2 The review is commissioned in accordance with Section 9, The Domestic Violence, Crime and Victims Act 2004.

5.3 The Chair of the Mansfield Community Partnership has appointed Mr Gary Goose MBE to undertake the role of Independent Chair and Overview Author for the purposes of this review. Mr Goose will be supported by Mrs Christine Graham. Neither Christine Graham nor Gary Goose is employed by, nor otherwise directly associated with, any of the statutory or voluntary agencies involved in the review.

6 Purpose of the review

The purpose of the review is to:

2.1 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.

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

2.3 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.

2.4 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.

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

2.6 Highlight good practice.

3 The review process

3.1 The review will follow the Statutory Guidance for Domestic Homicide Reviews under the Domestic Violence, Crime and Victims Act 2004 (revised 2016).

3.2 This review will be cognisant of, and consult with, any on-going criminal justice investigation and the process of inquest held by HM Coroner.

3.3 The review will liaise with other parallel processes that are on-going or imminent in relation to this incident in order that there is appropriate sharing of learning.

3.4 Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

4 Scope of the Review

The review will:

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

4.2 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.

4.3 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.

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

4.5 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.

4.6 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.

5 Family involvement

5.1 The review will seek to involve the family in the review process, taking account of who the family may wish to have involved as lead members and to identify other people they think relevant to the review process.

5.2 We will seek to agree a communication strategy that keeps the families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this.

5.3 We will work with the police and coroner to ensure that the family are able to respond effectively to the various parallel enquiries and reviews avoiding duplication of effort and without increasing levels of anxiety and stress.

6 Legal advice and costs

6.1 Each statutory agency will be expected and reminded to inform their legal departments that the review is taking place. The costs of their legal advice and involvement of their legal teams is at their discretion.

6.2 Should the Independent Chair, Chair of the CSP or the Review Panel require legal advice then Mansfield Community Partnership will be the first point of contact.

7 Media and communication

7.1 The management of all media and communication matters will be through the Review Panel.