# LONDON BOROUGH OF BEXLEY COMMUNITY SAFETY PARTNERSHIP

# DOMESTIC HOMICIDE REVIEW

## Executive Summary into the Death of Victoria, 2018

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## Contents

## 1. The Review Process

1.1. This summary outlines the process undertaken by Bexley Community Safety Partnership Domestic Homicide Review Panel in reviewing the death of Victoria who was a resident in their area.

1.2. Victoria (pseudonym used) was a woman aged in her late 30s/early 40s, of White British ethnicity.

1.3. The conclusion of the coroner as to her death was “drug related”.

1.4. Undertaking Reviews in cases such as these is framed by the Home Office Domestic Homicide Review Statutory Guidance which states: “Where a victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable.”

1.5. The process began with an initial meeting of the Community Safety Partnership when the decision to hold a Domestic Homicide Review was agreed, due to Victoria’s experiences in accessing services for a range of issues. All agencies that potentially had contact with Victoria prior to the point of death were contacted and asked to confirm whether they had been involved with them.

## 2. Contributors to the Review

2.1. This Review has followed the statutory guidance for Domestic Homicide Reviews (2016) issued following the implementation of Section 9 of the *Domestic Violence Crime and Victims Act 2004*. On notification of the death agencies were asked to check for their involvement with any of the parties concerned and secure their records.

2.2. The following agencies contributed to this Review:

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| Bexley Mind |
| Bexley Women’s Aid |
| Change, Grow, Live (CGL) Greenwich |
| General Practices (2) |
| Her Centre |
| Housing for Women |
| Hurley Group Urgent Care Centres |
| Kings College Hospital NHS Foundation Trust, including the Havens |
| Lewisham and Greenwich NHS Foundation Trust |
| London Borough of Bexley Community Safety MARAC and IDVA |
| London Borough of Bexley Children’s Social Care |

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| London Borough of Bexley Housing |
| London Ambulance Service |
| Metropolitan Police Service |
| Oxleas NHS Foundation Trust |
| Peabody |
| Royal Borough of Greenwich Adult Social Care |
| Royal Borough of Greenwich Housing |
| South London and Maudsley NHS Foundation Trust |
| Thames Reach |
| Victim Support |

2.3. Agencies contributed to the Review through Individual Management Reviews (IMRs). These set out the contact each agency had with Victoria, and analysed that contact with reference to the key lines of enquiry in the Review. These were shared and discussed at the Review Panel where additional learning was identified, and included in the Review.

2.4. The IMRs were written by authors independent of case management or delivery of the service concerned. Most IMRs received were comprehensive and enabled the panel to analyse the contact with Victoria, and to produce the learning for this review. Where necessary IMRs were asked to be re-submitted, as well as further questions being sent to agencies; responses were received. Fifteen IMRs made recommendations of their own. The IMRs identified changes in practice and policies over time.

## 3. The Review Panel Members

3.1. The Review Panel comprised:

| **Panel Member** | **Organisation** |
|---|---|
| Head of Safeguarding | Bexley Clinical Commissioning Group |
| Recovery Manager | Bexley Mind |
| Chief Executive Officer | Bexley Women's Aid |
| Services Manager | Change, Grow, Live (CGL) Greenwich |
| Chief Executive Officer | Her Centre |
| Manager | Housing for Women |
| Assistant Director of Operations and Nursing | Hurley Group Urgent Care Centres |
| Safeguarding Adults Specialist | Kings College Hospital NHS Foundation Trust, including the Haven |
| Adult Safeguarding Manager | Lewisham and Greenwich NHS Foundation Trust |
| Head of Adult Safeguarding | London Borough of Bexley Adult Social Care |

| | |
|---|---|
| Domestic Abuse and Sexual Violence Strategy Manager | London Borough of Bexley Community Safety including MARAC[1] and IDVA[2] |
| Service Manager | London Borough of Bexley Children's Social Care |
| Team Leader | London Borough of Bexley Housing |
| Safeguarding Adults Specialist | London Ambulance Service |
| Review Officer, Serious Crime Review Group | Metropolitan Police Service |
| Safeguarding Clinical Quality Manager | NHS England |
| Director of Nursing | Oxleas NHS Foundation Trust |
| Head of Community Safety and Support | Peabody |
| Addictions Governance/Senior Nurse Complex Needs | South London and Maudsley NHS Foundation Trust |
| Lead Outreach Worker | Thames Reach |
| Senior Operations Manager | Victim Support |

3.2. *Independence and expertise*: Agency representatives demonstrated an appropriate level of expertise throughout the Review and were independent of the case and line management of the case.

3.3. The Review Panel met a total of four times, with the first panel meeting in January 2019 and the final meeting in September 2019.

3.4. The Chair of the Review wishes to thank everyone who contributed their time, patience and cooperation to this review.

## 4. Chair of the Review and Author of the Overview Report

4.1. The Chair and Author of the Review is Althea Cribb, an Associate DHR Chair with Standing Together Against Domestic Violence (STADV). Althea has received Domestic Homicide Review Chair's training from STADV and has chaired and authored twenty reviews. Althea has over twelve years of experience working in the domestic violence and abuse sector, currently as a consultant supporting local strategic partnerships on their strategy and response to domestic violence and abuse.

4.2. Standing Together Against Domestic Violence (STADV) is a UK charity bringing communities together to end domestic abuse. We aim to see every area in the

[1] Multi-Agency Risk Assessment Conference: A risk management meeting where professionals share information on victims of domestic abuse at high risk, and put in place a risk management plan.
[2] Independent Domestic Violence Advocacy Service: Nationally recognised specialist support service victims of domestic abuse at high risk.

UK adopt the Coordinated Community Response (CCR). The CCR is based on the principle that no single agency or professional has a complete picture of the life of a domestic abuse survivor, but many will have insights that are crucial to their safety. It is paramount that agencies work together effectively and systematically to increase survivors' safety, hold perpetrators to account and ultimately prevent domestic homicides.

4.3. *Independence:* Althea Cribb has no connection with Bexley Community Safety Partnership, nor any of the agencies involved in this case.

## 5. Terms of Reference for the Review

5.1. At the first meeting, the Review Panel shared brief information about agency contact with Victoria, and established the time period to be reviewed, to cover the time of Victoria's significant contact with agencies. Agencies were asked to summarise any relevant prior contact they had with Victoria.

5.2. *Key Lines of Inquiry:* The Review Panel identified and considered the following case specific issues:

- The communication, procedures and discussions, which took place within and between agencies.
- The co-operation between different agencies involved with Victoria.
- The opportunity for agencies to identify and assess Victoria's issues (including abuse, drug/alcohol use, past trauma, housing instability).
- Agency responses to any identification of Victoria's issues.
- Organisations' access to specialist services responding to Victoria's issues.
- The policies, procedures and training available to the agencies involved on Victoria's issues.

5.3. The Review Panel ensured members included specialists in the areas for which Victoria needed and sought support.

5.4. To protect the confidentiality of those connected with Victoria, the full information gathered by the Review about Victoria is not presented in this Executive Summary. The Review concerned itself with Victoria's contact with agencies and what could be learnt in relation to how she was supported.

## 6. Summary of Chronology

6.1. In the terms of reference timeframe Victoria had contact with 22 different agencies. They recorded Victoria's experiences and issues:

- experiences of trauma and loss

- experiences of domestic abuse
- alleged sexual assault by a stranger near her home
- relationship with her children
- uncertain and unstable housing situation
- ongoing mental ill health (depression, post-traumatic stress disorder) that did not appear to improve for any length of time
- ongoing use of substances (different legal and illegal drugs, alcohol) from which she did not appear to stay abstinent for very long

6.2. Victoria had significant contact with the services listed in paragraph 2.2 from 2014-2017 in relation to one or more of the issues listed above. During 2017 her contact with services declined, and stopped completely three months before she died.

## 7. Conclusions and Key Issues Arising from the Review

7.1. The Review attempted to establish where Victoria was living when she presented to different agencies but this proved to be difficult and there were times when the Review could not establish where Victoria was living. As well as moving between addresses, Victoria moved between Bexley and Greenwich. Additionally, in order to access acute health care Bexley residents must travel to Bromley or to Greenwich, and this added to the difficulties for the Review in establishing which agencies she had received support from and where she was living at that time.

7.2. Victoria was offered a great deal of support from agencies in response to her varying needs. Many practitioners were proactive in their attempts to work with Victoria, and flexible in their approach to enable her to address her needs. Nevertheless, Victoria's problems, and the impact on her wellbeing, appeared to remain:

- Victoria's mental ill-health due to experiences of trauma
- Victoria's (changing) drug and alcohol use
- Victoria's experiences of domestic abuse and alleged sexual assault
- Victoria's situation as a mother who did not have the care of her children
- Victoria's unstable/uncertain housing situation

1.1.2. This Review has shown that most agencies were either not aware of the totality of Victoria's situation, or were focused on one issue from the list above, without recognising or attempting to address (potentially in a multi-agency way) the ways in which these issues affected Victoria, and interacted with each other to

affect her. It must therefore be seen that the learning in response to Victoria's experiences represents a whole system issue.

## 8. Lessons to be Learned

8.1. The Bexley Domestic Abuse and Sexual Violence Strategy Manager informed the Review that a domestic abuse campaign was developed in 2018 and continues to grow to ensure that multi agency partners respond effectively to domestic abuse. This includes a dedicated four level training package on domestic abuse and violence against women and girls and is offered to multi agency partners. The package includes stalking and harassment training, and 'honour'-based abuse training. A dedicated multi agency website has been developed with targeted campaigns.

8.2. A Domestic Abuse Partnership Strategic Group is in place to provide a strategic overview of the multi-agency response to domestic abuse within Bexley. It provides a collaborative approach ensuring a victim focused, efficient and effective practice. The group reports to Bexley Community Safety Partnership (BCSP) Board and an annual report is submitted to BCSP Board, Safeguarding Children's Board (SHIELD) and Safeguarding Adults Board. This demonstrates Bexley's commitment to a whole system approach and response to domestic abuse.

8.3. A training programme is in place. It is offered to all partner agencies who may come into contact with victims of domestic abuse and the dates for the training are scheduled in advance and are ongoing. Coercive and controlling behaviour is included in the training.

8.4. The following themes emerged from the IMRs and Review Panel discussions.

8.5. *Use of language, how domestic abuse is recorded, and how this reflects organisational cultures*: The Review Panel discussed how their use of language potentially reflected a culture across many organisations that focuses on victims of domestic abuse to the exclusion of the perpetrators. While recognising that services and responses to victims are essential and should be prioritised, this should not be done at the cost of making the perpetrator invisible. A recommendation is made (1).

8.6. The Review Panel acknowledged that knowledge and understanding of the offence of coercive and controlling behaviour is not where it needs to be. Recommendations are made (2 and 3).

8.7. *Collective risk assessment and management, with all available information*: There could have been more MARAC meetings to discuss Victoria's needs; and those that did take place did not adequately share information and address her risks. All agencies need to recognise and meet their responsibilities to identify domestic abuse victims, refer and share information, attend meetings and act on the plans made at MARAC. Recommendations are made (4 and 5).

8.8. In 2017 X pleaded guilty to assaulting Victoria (see paragraph 3.3.134) and was bailed from court to await sentence. The bail conditions that had been in place between the assault in August and the court appearance in September were not continued. Later that same day, X attended Victoria's home and allegedly assaulted her (he pleaded not guilty and the charge was not proceeded with). The bail conditions should have been continued by the court until sentencing had been completed. Consideration could also have been given to issuing a restraining order3. A recommendation (11) is made.

8.9. *Multi-agency, family approach covering information about the actions of all agencies*: In addition to the above learning for MARAC, in which existing processes were not used to their full extent to identify and manage Victoria's risks, organisations involved in this Review recognised that their staff could and should have organised a multi-agency professionals' meeting for Victoria. Information was not shared within and between agencies and departments and some agencies did not have the full picture of Victoria's life. Many practitioners worked very hard to support Victoria, and there was at times a high level of contact between agencies. This communication was often limited to the single issue that the organisation was addressing with Victoria, e.g. her drug/alcohol use, or housing benefit claim. This meant that practitioners were often not working with Victoria in a holistic way. Recommendation are made (6 and 7).

8.10. *The need for professionals to be questioning and reflective, in a trauma informed way*: At times during professionals' contact with Victoria there was a lack of professional curiosity or enquiry into her whole life and circumstances and the impact of these on her life and wellbeing. While Victoria's complicated and vulnerable situation was often recognised by practitioners, and some were aware of the range of issues she faced, there was nevertheless often a focus on just

[3] "Section 12 of the Domestic Violence Crime and Victims Act 2004 amended section 5A into the Protection from Harassment Act 1997 to allow the court to make a restraining order following a conviction for any criminal offence." See: https://www.cps.gov.uk/legal-guidance/restraining-orders-section-5-protection-harassment-act-1997

one of those issues without exploring how these experiences and ongoing issues interacted and impacted on her. Bexley Mind informed the Review Panel that, as they have experience of working in this way with their client group, they could offer other agencies support and training on this. A recommendation is made (8).

8.11. *Support for children and young people*: The Review Panel recognised that children and young people may need support when domestic abuse has occurred, and also later, and their support needs may change over time. The Review received information about work ongoing to address this in the Royal Borough of Greenwich. A recommendation is made (9).

## 9. Recommendations from the Review

9.1. The recommendations below should be acted on through the development of an action plan, with progress reported on to the Bexley Community Safety Partnership within six months of the review being approved by the partnership.

9.2. *Recommendation 1*: Community Safety Partnership to share this learning from the Review and request all organisations in Bexley to review policies, procedures, guidance and training to ensure that accurate language is adopted that reflects responsibility for domestic abuse (the nature of this will be specific to each organisation and their requirements).

9.3. *Recommendation 2*: Community Safety Partnership and other partnership boards[4] in Bexley to communicate to all members the learning from this case and the need for accurate recording of the facts, not of opinions, unless these have been corroborated, and to ensure that in cases of domestic abuse the victim's voice is present.

9.4. *Recommendation 3*: All services and agencies to ensure they have an appropriate Domestic Abuse Champion in place, and that all Champions have accessed the relevant Level 3 Borough-wide training on domestic abuse, which includes coercive and controlling behaviours.

9.5. *Recommendation 4*: Domestic Abuse Partnership Strategic Board and MARAC Steering Group to put in place an escalation process to address any issues in agency referrals, meeting attendance, information sharing and completing of actions in relation to MARAC.

[4] Local Safeguarding Children's Board (SHIELD), Adult Safeguarding Board, Health and Wellbeing Board, Bexley Voluntary Sector Council

9.6. *Recommendation 5*: Community Safety Partnership to receive assurances from core MARAC agencies that leads are identified and consistently attend MARAC. MARAC Coordinator to ensure that agency MARAC representatives receive appropriate inductions to their role.

9.7. *Recommendation 6*: MARAC to ensure that, when an individual is discussed and they are seen to have a high level of needs, an appropriate lead practitioner is identified who coordinates an additional professionals' meeting.

9.8. *Recommendation 7*: Community Safety Partnership, and other partnership boards in Bexley, to communicate to all members the expectation that organisations will support and train staff to be proactive in calling professionals' meetings when required for service users.

9.9. *Recommendation 8*: Community Safety Partnership and other partnership boards in Bexley to communicate to all members the learning from this case and the need for professionals to appropriately enquire into service users' histories, social and family circumstances and how these may impact on their ongoing needs; and to consider the impact of any trauma on service users' behaviours. For agencies to, as appropriate to their role, share this within internal communications and supervision and seek training.

9.10. *Recommendation* 9: Local Safeguarding Children's Board (SHIELD) and the Bexley Domestic Abuse Partnership Strategic Board to learn from good practice in Greenwich and elsewhere about what works in responding to children and young people who have experienced domestic abuse from a parent or a parent's partner. To act locally to work towards addressing this gap.

9.11. *Recommendation 10*: Home Office to develop and make available a leaflet about Domestic Homicide Reviews for friends and family of those deceased through suicide.

9.12. *Recommendation 11*: Community Safety Partnership, Bexley Magistrate's Court and local Crown Prosecution Office representatives to review the response to domestic abuse cases that come to court, with reference to the learning identified in this Review, to ensure that bail conditions are appropriately put in place and restraining orders are consistently considered.