Domestic Homicide Review

under section 9 of the Domestic Violence Crime and Victims Act 2004

In respect of the death of "Susan"

In November 2015

Report produced for Safer Kensington and Chelsea Partnership by
Paula Harding
Independent Chair and Author
August 2019

GLOSSARY

AAFDA: Advocacy After Fatal Domestic Abuse
CSP: Community Safety Partnership
CCG: Clinical Commissioning Group
CCTV: Closed Circuit Television
DASH: Domestic abuse, stalking and harassment risk assessment model
DoH: Department of Health
DHR: Domestic Homicide Review
DVA: domestic violence and abuse
FCA: Financial Conduct Authority
GP: General Practitioner
IMR: Individual Management Review – reports submitted to review by agencies
IRIS: Identification and Referral to Improve Safety - a general practice-based domestic violence and abuse training support and referral programme
MERLIN: a database run by the Metropolitan Police that stores information on children who have become known to the police for any reason
NICE: National Institute for Health and Care Excellence
PAC: A pre-assessment check undertaken by the police in respect of child protection
PACE: Police and Criminal Evidence Act 1984. Section 17(1) of the Act concerns the police's powers of entry into a premises
SPECSS+: Domestic abuse risk assessment model formerly used by the Metropolitan Police. The assessment of risk was based on six prominent risk factors outlined in SPECSS+ (Separation (child contact), Pregnancy (new birth), Escalation, Culture (community isolation and barriers to reporting), Stalking and Sexual Assault).
TMO: Tenancy Management Organisations have been established under HM Government's Housing (Right to Manage) Regulations (1994) to enable social housing tenants to manage all or part of their landlord's duties themselves.

Table of Contents

PREFACE **5**

1. INTRODUCTION **5**

1.1. Aim and Purpose of a domestic homicide review 5
1.2. Summary of the circumstances leading to the review 6

2. TERMS OF REFERENCE **6**

2.1. Methodology 6
2.2. Independent Chair and Overview Author 7
2.3. Members of the Review Panel 8
2.4. Key Lines of Enquiry 8
2.5. Time Period 9
2.6. Individual Management Review Reports (IMRs) 9
2.7. Agencies without contact 10
2.8. The definition of domestic violence 11
2.9. Parallel Reviews 12
2.10. Involvement of Family and Friends 12
2.11. Equality, Diversity and Vulnerability 13
2.12. Dissemination 13

3. BACKGROUND **13**

3.1 Persons involved in this review and their confidentiality 14

4. OVERVIEW **21**

4.1 Metropolitan Police Service 21
4.2 Primary Care ..... **Error! Bookmark not defined.**
4.3 Adult Social Care 24
4.4 Royal Borough of Kensington and Chelsea Housing Management 24

5. THEMATIC ANALYSIS, LEARNING & RECOMMENDATIONS **26**

5.1 Awareness of domestic violence and abuse 26
5.2 Alcohol misuse and domestic abuse 28
5.3 Economic abuse and debt 29
5.4 Co-ordinate community response & individual agency recommendations ..... **Error! Bookmark not defined.**

6. CONCLUSION **33**

7. BIBLIOGRAPHY **34**

8. ACTION PLANS **36**

PREFACE

Safer Kensington and Chelsea Partnership, the independent chair and members of the review panel offer their deepest sympathy to the family and to all who have been affected by Susan's[1] death

It is a requirement of domestic homicide reviews that the names of persons involved in this review be anonymised in order to protect the confidentiality of the surviving family and others. For this reason, the victim is referred to as 'Susan'. Her family are also provided with pseudonyms.

The victim's daughters will be invited to contribute a personal statement to introduce this review and the impact of their mother's death upon them

1. INTRODUCTION

1.1. Aim and Purpose of a domestic homicide review

1. Domestic Homicide Reviews (DHRs) came into force on the 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR should 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 she was related or with whom she was or had been in an intimate personal relationship or (b) member of the same household as herself; with a view to identifying the lessons to be learnt from the death.

2. The purpose of a 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; and identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra- and inter-agency working.

3. In summary, the key purpose for undertaking a domestic homicide review is to enable lessons to be learned where a person is killed as a result of domestic violence, abuse or neglect. In order for these lessons to be learned as widely and thoroughly as possible,

[1] Not her real name

professionals need to be able to understand fully what happened in the life of the homicide victim, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.2. Summary of the circumstances leading to the review

4. This domestic homicide review concerns the death of Susan. At the age of forty-eight, her death was discovered after family members had been unable to contact her or her partner for several days.

5. As concerns grew, the police forced entry to the sixteenth floor flat and found Susan having suffered fatal head injuries. CCTV revealed that her partner had thrown himself forty-six metres off the balcony of their flat around the time that the police arrived.

6. Although two suicide letters had been left, the police investigation concluded that Susan was killed by her partner before he took his own life. The inquest into the deaths took place at Westminster Coroners Court in August 2016 and the Coroner recorded a verdict of unlawful killing in the case of Susan, who had received a blunt force trauma to the head, and an open verdict in the case of her partner.

TERMS OF REFERENCE

2.1. Methodology

7. The review process has followed the Multi-Agency Statutory Guidance on the Conduct of Domestic Homicide Reviews (as amended in December 2016).

8. Safer Kensington and Chelsea Partnership were notified of Susan's death in November 2015. All local agencies were asked to examine their records to establish if they had been approached by or provided any services to the family and to secure records if there had been any involvement. A decision was made by the Chair of the Partnership to undertake a domestic homicide review on 20th March 2016 and the Home Office were notified of this decision. Thereafter, arrangements were made to appoint an Independent Domestic Homicide Review Chair and agree the make-up of the multi-agency review panel.

9. The Senior Investigating Officer in charge of the homicide investigation from the Metropolitan Police attended the first panel meeting and was able to provide detail on the findings of the criminal investigation and latterly the inquest, both of which have been incorporated into this review.

10. The Terms of Reference were drawn up by the Independent Chair together with the review panel incorporating key lines of enquiry and specific questions for individual agencies where necessary. Individual Management Reviews (IMRs) were requested to be

undertaken as well as information reports from agencies with less involvement. A briefing and written guidance was made available for IMR authors by the Independent Chair.

11. The panel met seven times, during which, panel members were able to discuss the progress of the review and request further clarification and additional material, where needed. All panel meetings were minuted and all actions agreed for the panel have been tracked and completed. The panel considered and agreed the draft Overview Report and the final Overview Report was presented to Safer Kensington and Chelsea Partnership prior to submission to the Home Office.

12. Whilst the decision to undertake a domestic homicide review had been undertaken swiftly, the review has faced significant unexpected delays. An independent chair and author was engaged but due to circumstances beyond their control, was unable to finalise the review. There were also significant attempts made over time to contact the bereaved family. Nonetheless, agencies did not delay in acting upon the findings from the review as they emerged including developing a domestic homicide review protocol which will address such delays in the future.

2.2. Independent Chair and Overview Author

13. The role of Independent Chair and Overview Author was taken over in February 2019 by Paula Harding, who has compiled the final Overview Report and Executive Summary.

14. Paula Harding has over twenty-five years' experience of working in domestic violence and abuse with both senior local authority management and specialist domestic violence sector experience. For more than twelve of those years she was a local authority strategic and commissioning lead for violence against women and has been an independent chair and author of domestic homicide and safeguarding adult reviews since 2016.

15. She completed an M.A. (Birmingham) in Equalities and Social Policy in 1997, focusing on domestic violence and social welfare, and is a regular contributor to conferences, national consultations and academic research. She completed the OCR certificated training, funded by the Home Office, for *Independent Chairs of Domestic Homicide Reviews* in 2013. She has also completed the on-line training provided by the Home Office: *Conducting a Homicide Review*[2].

16. Beyond this review, Paula Harding had not been employed by Safer Kensington and Chelsea Partnership.

[2] Available at https://www.gov.uk/guidance/conducting-a-domestic-homicide-review-online-learning

2.3. Members of the Review Panel

17. Multi-agency membership of this review panel consisted of senior managers and/or designated professionals from the key statutory agencies. The Panel members had not had any direct contact or management involvement with Susan or her partner and they were not the authors of the Individual Management Review reports that their organisations provided.

18. Wider matters of diversity, equality and vulnerability were considered when agreeing panel membership. Standing Together Against Domestic Violence, a specialist domestic abuse organisation, provided independent expertise on domestic abuse and the 'victim's perspective' to the panel. Likewise, the Drug and Alcohol Wellbeing Service provided independent expertise on alcohol as a feature of this review.

19. Alongside the change in the independent chair, the review panel members also changed over time. The panel members agreeing the final overview report were:

    - Paula Harding, Independent Chair and Author
    - Jane Downing, Designated Nurse Safeguarding Children, Central London and West London CCGs, North West London Collaboration of Clinical Commissioning Groups
    - Janice Cawley, A/Detective Inspector, Metropolitan Police
    - Jonathon Kent, Detective Inspector (Safeguarding), Metropolitan Police
    - Julie Ryan, Drug and Alcohol Wellbeing Service
    - Joanne Davidson, Victim Support
    - Mary Wynne, Safeguarding Adults Lead, Royal Borough of Kensington and Chelsea Adult Social Care?
    - Nicci Wotton, Consultant Nurse for Safeguarding/Named Nurse Safeguarding Children, Imperial College Healthcare NHS Trust
    - Sally Jackson, Partnership Manager, Standing Together Against Domestic Violence
    - Sandy McDougall, Royal Borough of Kensington and Chelsea Housing Services
    - Shabana Kausar, Violence Against Women Strategic Lead for Boroughs of Westminster, Hammersmith & Fulham, and Kensington & Chelsea

2.4. Key Lines of Enquiry

20. The review sought to address both the 'circumstances of a particular concern' set out in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2013) and (2016). The key lines of enquiry emerged as the review progressed and sought:

    - To seek to view the circumstances and agency responses from Susan's perspective.
    - To establish what contact agencies had with the victim and the perpetrator; what services were provided, individually and in partnership; and whether these services were appropriate, timely and effective.

- To establish whether agencies knew, or could have known, about domestic abuse and what actions they took to safeguard and meet the needs of the victim and manage the threat from perpetrator.
- To consider how issues of alcohol, substance misuse, mental health or any other issues of vulnerability or diversity impacted upon the delivery of services and whether needs or risk arising from these factors were addressed.
- To consider the financial hardship of the household: how debts were managed and its relationship to potential economic abuse.
- To consider whether debt collection was undertaken in adherence with the law and relevant codes of conduct.
- To establish how well-equipped staff were in responding to the needs, threat or risk identified for the family through policies and procedures; management and supervision; training; capacity and resources to meet expected standards of practice.
- To establish what lessons can be learned from the case about the way in which professionals and organisations carried out their duties and responsibilities.
- To identify clearly what those lessons are, how (and within what timescales) they will be acted upon and what is expected to change as a result through the production of a multi-agency action plan
- To recommend to organisations any appropriate changes to such policies and procedures as may be considered appropriate in the light of this review

21. Individual agencies were also asked to respond to specific questions as featured below.

2.5. Time Period

22. The panel agreed that the review should focus on the two calendar years before the victim's death in order to consider most current practice responses to domestic abuse. However, the timeline was extended for the Metropolitan Police Service who were asked to consider their contact with the couple from January 2004 to take into account the two incidents of domestic abuse reported during that year. Contextual information outside of this timeframe has been provided by other agencies and has been included in the chronology.

2.6. Individual Management Review Reports (IMRs)

23. An IMR and comprehensive chronology was provided by the Metropolitan Police Service

24. Chronology and/or information reports were provided by:

- The GP Practice
- Littlewoods
- Royal Borough of Kensington and Chelsea Adult Social Care

- Royal Borough of Kensington and Chelsea Housing Management in respect of records held by the former Kensington and Chelsea Tenancy Management Organisation
- Royal Borough of Kensington and Chelsea Family Services in respect of involvement in earlier times, provided for contextual purposes only

25. The victim's tenancy was managed by a Tenancy Management Organisation which has since ceased to operate. Records were transferred to the local authority who were asked whether the TMO been aware of domestic abuse within the household or could any issues in the tenancy have been indicators of domestic abuse? However, there were no records or indicators of domestic abuse on the records transferred. The local authority was also asked whether there were any problems on the tenancy, such as rent arrears, nuisance, anti-social behaviour and if so, how did the TMO deal with any issues and the response features in the section considering debt below.

26. Littlewoods was asked to respond to the following questions in respect of a catalogue debt that Susan had with them:

    - Whether the debt had been sold or assigned to another company to collect, the individual debt reference and contact details for that company
    - If the debt had not been assigned, the details of debt recovery, including all attempts made to contact the victim and arrangements made
    - Whether debt recovery complied with relevant industry codes of conduct

27. All agency reports were authored by professionals who had not had any direct contact or management involvement with the victim or her family.

2.7. Agencies without contact

28. The following agencies were contacted but confirmed that the couple had not been known to them, or their involvement was not relevant to this review:
    - Advance
    - Eaves
    - Central and Northwest London NHS Foundation Trust (mental health services)
    - Drug and Alcohol Wellbeing Service
    - Royal Borough of Kensington and Chelsea Housing Needs
    - Standing Together Against Domestic Violence
    - Victim Support

2.8. The definition of domestic violence

29. The Government's definition of domestic violence, which sets the standard for agencies nationally was applied to this review:

"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

- *psychological*
- *physical*
- *sexual*
- *financial*
- *emotional*

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.
Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

(HM Government, 2013)

30. At the time of writing, HM Government is proposing to introduce legislation in the Domestic Abuse Bill (published 21 January 2019) which, amongst other things, will introduce a statutory definition of domestic abuse. The proposed statutory definition will include the elements of coercive control as well as economic abuse, each of which are relevant to this review.

31. Although not yet enshrined in legislation, economic abuse is considered to encompass a range of behaviours including

- Preventing acquisition of economic resources such as interfering with/sabotaging partner's education, training and employment; insisting that partner's wages are paid into the perpetrator's bank account; preventing a partner from claiming welfare benefits; denying partner access to personal/joint bank account.
- Controlling access to/preventing use of individual or shared economic resources such as: making partner ask for money; demanding to know how money is spent; monitoring expenditure; keeping financial information secret; making important financial decisions without discussing them first; making partner ask to use car; threatening to throw partner out.
- Refusing to contribute by withholding financial support for the household such as: refusing to contribute towards household bills and the cost of bringing up children, whilst spending own money on non-essential items.
- Exploiting economic resources and/or generating economic costs such as: making partner work for personal/jointly owned business with no pay; using coercion/fraud to build up debt in partner's name; spending money needed for bills; putting all financial

liabilities in partner's name; destroying household goods and personal items; stealing from partner's purse. (Sharp, 2008; Sharp-Jeffs & CWASU, 2015)

32. We will see that a number of these aspects of economic abuse were evident in the perpetrator's behaviour.

2.9. Parallel Reviews

33. There were no criminal proceedings as the police were satisfied that David was the perpetrator of the homicide and had taken his own life afterwards. The inquest confirmed that Susan had been unlawfully killed and recorded an open verdict for David.

34. As the family had raised concerns about the police response on the evening that the victim was found, the matter was reported to the Independent Police Complaints Commission.[3] They made a decision that the issue could be managed internally by the Metropolitan Police, whose Directorate of Professional Standards found no misconduct or organisational learning. The panel was not aware of any other parallel inquiries being undertaken.

2.10. Involvement of Family and Friends

35. The review panel recognised that family members and those close to the victim can provide valuable understanding about the victim's life and experiences and contribute a valuable perspective that professionals and agencies cannot provide.

36. Each Independent Chair approached contact with family members using the evidence-based principles of family involvement (Brandon et al. 2012). After several attempts were made to contact them directly or through support agencies, it was understood that family members had declined to engage with the review but the Home Office Leaflet for Family Members[4] together with details of the support available from Advocacy After Fatal Domestic Homicide Abuse (AAFDA) have been shared with them. Further letters were delivered when the overview report had been drafted but no response was received. All family members will be notified about the report before publication and engagement and support will be offered again at this time.

37. Consideration was given to consulting with Susan's friend and neighbour for whom she cared, but because of the degree of her dementia, this was not considered possible.

38. Letters were also written to those neighbours who lived in close proximity to Susan's home, inviting them to contribute to the review and enclosing Home Office explanatory leaflets. This was seen as important as some neighbours had provided witness statements to the police concerning an increase in noise and damage to the hallway shortly before

[3] Now known as the Independent Office for Police Conduct
[4] Available at https://www.gov.uk/government/publications/domestic-homicide-review-leaflet-for-family

the deaths. No response was received, and they were deemed to have declined the invitation.

2.11. Equality, Diversity and Vulnerability

39. The review gave due consideration to issues of equality, diversity and vulnerability alongside each of the protected characteristics under Section 149 of the Equality Act 2010. Susan was a forty-eight-year-old, heterosexual, white woman of British nationality. David was a fifty-five-year-old, heterosexual, white man of British nationality. They were not married.

40. The impact of a victim's sex has been an enduring feature of domestic homicides. In the three years surrounding the victim's death, seventy per cent of victims of domestic homicide were female. (ONS,2017).

41. In terms of disability, the perpetrator was epileptic He had also sustained two head injuries in previous times but was not known to have any residual brain injury which might affect his health, behaviour or needs. Alcohol also appeared to be a pervasive feature in their lives, but it is not known whether the degree of alcohol use was sufficiently problematic to each of the individual's health and well-being as to constitute a disability. Nonetheless, disability and problematic alcohol use have been viewed as creating vulnerabilities in the household, rather than factors causing abusive behaviours.

42. Socio-economic disadvantage is not a protected characteristic under the Equality Act. However, the area in which Susan and David lived is one characterised by a steep division between great affluence and poverty. Indeed, income inequality is higher here than any other London borough by a considerable margin (Trust for London, 2017). The panel were keen to ensure that the review considered vulnerability as a result of socio-economic disadvantage amongst the equality issues.

43. In this way sex, culturally defined gender roles, socio-economic disadvantage and disability were considered relevant to this review and will be considered in the report below.

2.12. Dissemination

44. The following organisations will receive copies of this review

- Safer Kensington and Chelsea Community Safety Partnership and its agencies
- Mayor's Office for Policing and Crime
- All agencies involved in the review and beyond through publication on the Safer Kensington and Chelsea Partnership website

3. Distribution List:

Name	Agency	Position/ Title
Barry Quirk	RBKC	Chief Executive
Cllr Gerard Hargreaves	RBKC	Lead Member for Culture, Leisure and Community Safety
Sue Harris	RBKC	Executive Director for Environment and Communities
Stuart Priestley	RBKC	Chief Community Safety Officer
Mary Wynne	RBKC	Safeguarding Adults Coordinator
Shabana Kausar	RBKC	Strategic Lead for Violence Against Women and Girls
Louise Butler	RBKC	Safeguarding Coordinator, Adult Social Care
Nicola Ashton	RBKC	Strategic Commissioner of Public Health
Sally Jackson	Standing Together Against Domestic Violence	Partnership Manager
Catherine Knights	Central and North West London NHS Foundation Trust	Associate Director of Quality, Safety and Safeguarding
Jane Downing	Central London and West London CCGs, North West London Collaboration of Clinical Commissioning Groups	Designated Nurse Safeguarding Children
Nicci Wotton	Imperial College Healthcare NHS Trust	Consultant Nurse for Safeguarding/Named Nurse Safeguarding Children
Helen Harper	Metropolitan Police	RBKC Borough Commander
Stav Kokkinou	RBKC	Housing Management Services
Janice Cawley	Metropolitan Police	Detective Inspector
Jonathon Kent	Metropolitan Police	Detective Inspector (Safeguarding)
LaToya Ridge	Victim Support London	Senior Operations Manager
Julie Ryan	Drug and Alcohol Wellbeing Service	Family and Carers Team Coordinator Tri Borough Domestic Abuse, MARAC Lead & Woman's lead
Andrew Connelly	Littlewoods	Head of Consumer Affairs
Paula Harding	Independent Chair and Author	-
Quality Assurance Panel	Home Office	-

4. BACKGROUND

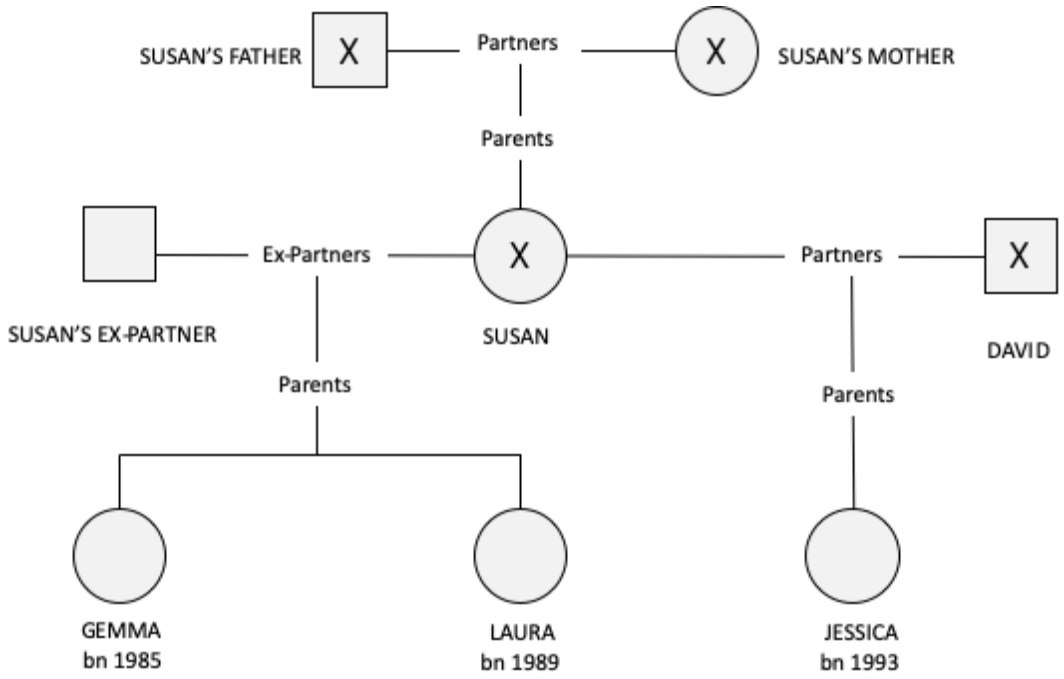
3.1 Persons involved in this review and their confidentiality

43. This Overview Report has been anonymised and, where stated, redacted.

44. In order to protect the identity of the victim, family and significant others, the following anonymized terms have been used throughout this report. Best practice would have pseudonyms chosen by the surviving family, but as engagement with the family was not possible, the most popular names at the time of each individuals' birth, have been chosen where culturally relevant (ONS,2014):

Pseudonym	*Relationship*	*Age at the time of the victim's death*	*Residing with victim at time of death*
Susan	The victim	48	-
David	The victim's partner	55	yes
Gemma	The victim's eldest daughter	29	No
Laura	The victim's middle daughter	27	No
Jessica	The victim's youngest daughter and daughter of David	21	No
-	The victim's mother	deceased	-
-	The victim's father	deceased	-

45. A genogram of the family is provided below:



46. Whilst the details of each review remain confidential, available only to participating professionals and their direct line management, the report has sought to extract sufficient detail from the victim's narrative for the lessons and recommendations to be understood, whilst balancing this need for confidentiality.

4. CHRONOLOGY & AGENCY INVOLVEMENT

47. The sections below have been based on information provided by agencies, summaries of the police investigation and the findings of the inquest. They represent the Independent Overview Author's view of significant information and events about the victim.

48. Susan and David had been in a relationship for twenty-two years and had one daughter. Susan been married before and already had two daughters who were aged approximately eight and five when the couple met. David already had one son, with whom he had little contact. All of the children had reached adulthood and were living independently by the time of their mother's death.

49. Both Susan and David were described by Susan's family as heavy drinkers. David was more likely to stay at home to drink, but Susan was more often socially drinking, and her drinking had brought her to the attention of the police for several years.

50. When her children were young, safeguarding concerns were raised in respect of Susan's alcohol misuse and neglect of them. It was not until her divorce in 1993 that it was noted in social care records that she had been experiencing domestic violence and abuse in this previous relationship and had had to seek a non-molestation order to protect herself and her children.

51. From the time Susan's relationship with David began in 1993, and their daughter, Jessica (pseudonym) was born, children's social care continued to be involved at various times until the children reached adulthood. Throughout this period, Susan's mother and father were supportive of the young family and their grandchildren would often stay with them, initially in the evenings and then overnight during the week. Children's social care were aware that David had threatened Susan's mother and father not to report their concerns regarding the welfare of the children.

52. Despite being fearful of David's threats of physical assault, Susan's mother and father were open with social care. Anonymous allegations were also made that David did not like the older children and made them eat from the floor. David was alleged to have subsequently assaulted Susan's father, but this allegation was later withdrawn. Despite these allegations, David appeared largely invisible to safeguarding and child protection interventions that continued intermittently throughout the girls' childhoods. Since this time, the social care response to domestic abuse in the context of child safeguarding and protection has developed significantly and whilst it is beyond the scope of this review to analyse the changes that have taken place over this extensive period of time, some comment has been made in the analysis which follows below.

53. Susan had taken the tenancy of her two-bedroomed local authority flat in 1992 which was a property managed by Kensington and Chelsea Tenancy Management Organisation. The tenancy was in Susan's sole name, but the landlord was informed when David was also living there. Susan claimed welfare benefits, including housing benefit, independently and

David was employed as a cleaner earning approximately £1000 per month. Susan was reported to be neighbourly, providing daily care to her neighbour who had dementia and was housebound.

54. Both David and Susan were known to the police individually before they were known as a couple and both had convictions for assault: David in 1981 and Susan in 1985. The context for these assaults is not known.

55. In 2002, Susan's parenting came to the attention of children's social care again and attempts were made to support Susan with her alcohol abuse over the following years, but she consistently denied that alcohol was a problem for her. This will be considered in the analysis.

56. The Metropolitan Police received two reports of David's domestic violence towards Susan. In the first report, in March 2004, Susan told the police that David had punched her in the mouth and officers noted that she had a cut lip and swelling to the mouth. Officers encouraged her to seek medical attention which she declined and, as Susan was drunk, they did not initially take a statement but went back the next day to obtain one. In the meantime, David had been arrested but claimed that Susan was often violent to him and on this occasion, she had hidden his epilepsy medication. He stated that the injury had been accidental, and he had been defending himself from her attack.

57. Susan provided a statement to police officers the following day but did not want to support a prosecution and she was provided with details of the local domestic abuse service. The Crown Prosecution Service reviewed the file and recommended that no further action be taken. It was recorded that Susan was at 'medium' risk through the risk assessment methodology that was used at the time, known as SPECSS+.[5] Although children were resident, their names were not captured on the crime report and their details were not assessed through the pre-assessment checklist (MERLIN) that was then used to determine whether children's social care would be notified of the incident[6].

58. Later that year, in December 2004, Susan contacted the police again reporting that David had punched her in the stomach. Both David and Susan were under the influence of alcohol. David was arrested and bailed but Susan later withdrew her statement denying the assault and David's bail was cancelled. Susan was provided with details of domestic abuse services but, on this occasion, the incident was incorrectly recorded as a 'domestic abuse non-crime'[7], no risk assessment was recorded, and no mention made of any children.

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[5] Since 2010, the Metropolitan Police have used the Domestic Abuse, Stalking and Harassment and Honour Based (DASH) Risk Model to assess risk.

[6] Under recent arrangements, schools in the borough are now also notified of incidents reports to the police through a national project known as Operation Encompass.

[7] Home Office Counting Rules for Recorded Crime require that the police record domestic reported incidents where a crime is thought to have taken place and those where non-crime is evident, known as a 'domestic abuse non-crime'. Further information can be found at

59. Neither of these domestic abuse incidents informed any actions in respect of safeguarding the children. The children had been taken off a Child Protection Plan in November 2003, but Children's Social Care were continuing to work with them as Children in Need. A review was undertaken in May 2004 which did not feature the domestic abuse incident. Jessica was reported missing to the police in June 2004 and whilst she was found at her grandmother's home, domestic abuse did not feature in the assessment that followed despite police involvement. Likewise, a home visit by social workers in December 2004 identified acrimonious behaviour between the couple but was not informed by police reports of domestic abuse.

60. At this time, Susan's landlord, Kensington and Chelsea Tenancy Management Organisation, were notified by Children's Social Care that Susan was experiencing problems with alcohol. No further records are available to identify the landlord's response.

61. Over the next ten years, the police received seven more reports in relation to Susan who was intoxicated on each occasion. Four of those involved Susan's own offending behaviour and one involved Susan experiencing an assault form an unknown male. The remaining two reports involved domestic abuse involving her eldest daughter and there was evidence of serious violence from both parties for which medical attention was received at hospital.

62. However, there were occasions when Susan had injuries that were not reported to the police. In May 2010, she attended Charing Cross Urgent Care Centre with David, having suffered a bone fracture to her right foot. She explained that she had fallen down the stairs a few days previously. She was referred to the fracture clinic and no other issues or injuries were noted. In 2011 she attended the Emergency Department with a cut hand from glass after an argument with a family member (not David). The notes indicated that she was intoxicated but she only disclosed having drunk two glasses of Bacardi, which would unlikely have caused intoxication.

63. In 2012, David, who was epileptic, suffered a seizure and fell. A seizure ten years prior had resulted in brain surgery and this seizure was seen to be a relapse. An MRI scan revealed that he had an enlarged frontal lobe, but there are no records indicating that this required any further treatment or affected his cognitive ability.

64. In June 2014, Susan was assessed by Adult Social Care in respect of her role as a carer for her elderly neighbour who had dementia and was housebound. She stated that she had been undertaking this role for the last seven years and was with her friend and neighbour from early morning until late at night, assisting her with domestic tasks and keeping her company. As a result of this telephone assessment, Adult Social Care provided a one-off payment in December 2014 and agreed to review the carer's assessment the following May. The victim was not specifically asked about domestic abuse and made no disclosures

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/721595/count-general-jul-2018.pdf

of domestic abuse during this assessment. She was also referred to the Income Maximisation Service for assistance with Carer's Allowance and to check for entitlement to other benefits. Nothing was recorded as to the reason behind this beyond the obvious need to improve her income.

65. In May 2015, David was dismissed from his job as a cleaner as a result of allegations of theft and deception being made against him. He was accused of having broken into a safe and taken money as well as falsifying shift hours and encouraging others to do so. His employment contract was terminated without notice or pay and whilst he had a right to appeal, he did not do so. He appeared to have hidden the fact that he had been dismissed from Susan and borrowed some money from his elderly mother who had dementia.

66. In August 2015, Adult Social Care commenced an overdue review of the carer's assessment that had been scheduled for May 2015. It is not known why this was not completed. If the victim was to continue receiving financial support from the local authority, they would have needed to do a further financial assessment of her needs.

67. By November 2015, Susan was in debt by over £1800 and David in debt by £143. It has not been made clear when the debts started but they mostly concerned catalogue debts and one of the creditors, Littlewoods, had put the matter into the hands of their internal collections team. Between the 14th November and 20th November 2015, the couple received twenty-eight calls from ten different numbers, all of which were attributed to Littlewoods internal collections team. Indeed, over the month prior to the death Littlewoods had made a total of fifty-one calls, none of which were answered. Further text messages had been sent from other creditors including a notification from Susan's mobile phone supplier that the service had been cut off.

68. At the same time as being in debt, Susan's rent account was in credit by over £500. The rent account had been in low level arrears between 2003 and 2011 which Susan consistently sought to repay. At this time, a sizeable backdate of housing benefit was received, leaving the rent account in credit, for the next four years until her death. This credit was despite Susan's benefit being affected by the under-occupation charge, known colloquially as the 'bedroom tax', since April 2013. This charge is applied to those in receipt of benefits where they are considered to have more bedrooms than they need. In Susan's case, her benefit was reduced by fourteen per cent as she was considered to be occupying a two-bedroomed flat and was deemed to only need one bedroom.

69. On the evening of 16th November 2015 David went on to try to borrow money from his daughter when Susan's mobile phone was disconnected. This was the last time that Susan was thought to have been seen or spoken with by someone other than David.

70. On the evening of 20th November 2015, the victim's eldest daughter, Gemma (pseudonym) contacted the police as she was concerned that she had not seen or spoken with her mother for four days and that this was unlike her. It is not known whether she knew about her mother's experience of domestic abuse and was more distressed by her disappearance as a result.

71. Having contacted the police, she became worried that the police were prepared to break the door down and so she decided to ring around the hospitals and custody suites herself, using the numbers that she had been given by the police call-operator, before formally reporting her missing.

72. At 21:43, Gemma contacted the police again and the call-operator advised that the police would attend her mother's home within an hour. Gemma, palpably distressed, phoned another eight times before the police arrived at 23:58. There had been no police units available as two other serious incidents were happening at the same time.

73. Having arrived at the sixteenth floor flat, officers did not suspect that anyone was in the premises. A draft-excluder blocked their view through the letterbox and there was no reply to either Susan or David's mobile phones or audible ringing tone to be heard from outside the flat. Officers requested a battering ram over the radio channel but there was no response. Believing there was no reason to force immediate entry, they returned to the station to collect a battering ram and to conduct missing persons checks.

74. Once at the station they undertook checks regarding hospital admissions, admissions to the custody suite and checks of the transaction log, all of which were returned without trace of either party. In the meantime, Gemma called the police a further three times enquiring how long the officers would be.

75. Roughly half an hour later, at 01:07, police officers forced entry. Having entered the flat, they found Susan deceased but were not aware of anyone else in the property. On the dining table the police found two envelopes: one addressed to the police, the other addressed to the couple's daughter Jessica. The balcony door of the flat was ajar, and, unbeknown to the police at the time, CCTV revealed that David had jumped the sixteen floors to his death around the time that police forced entry to the flat, at 01:12. He was found deceased at 02:21 hours.

76. In both letters, David had written about how much he loved Susan and had let her down by having lost his job and getting them into debt. He stated in both letters that Susan was unaware of him losing his job eight months previously and his letters were peppered with statements such as, *"It is because I loved her so much that I took her life…"* and *"…I have reached the end but I can't leave poor mummy on her own. I do everything for her because she is my life".*

77. In the letter addressed to his daughter, the perpetrator explained more detail about having sold Susan's jewellery without her knowledge; owing hundreds of pounds; Susan's phone having been cut off at the weekend; not having eaten for three days and Susan going to bed hungry. He did not leave letters for the victim's other daughters.

78. Witness statements taken after the murder revealed that one month before, one set of neighbours had heard banging, shouting and screaming coming from her flat over the weekends and in the evenings. They also witnessed a broken window on the landing and

stated that David had been shouting for Susan to let him in. As they said that they had not heard these noises before, it could be indicated that there had been an escalation of domestic violence and abuse in the period before the murder.

79. The post-mortem revealed that neither party were intoxicated when they died.

4. OVERVIEW

80. This section considers the Individual Management Reviews (IMRs) and Information Reports completed by the individual agencies and the panel's contribution to their analysis.

4.1 Metropolitan Police Service

81. Susan reported two incidents of David's domestic abuse to the Metropolitan Police in 2004. Due to the passage of time, it has been not possible to provide an explanation for the omissions made within police responses to these incidents in respect of crime recording, compliance with domestic abuse risk assessment and undertaking child safeguarding notifications. The Metropolitan Police have been able to evidence significant improvements in the police response to domestic abuse that have taken place in the intervening years.

82. Susan was also arrested for drink related disorder on seven occasions throughout the review period and the Metropolitan Police have highlighted the developing processes in custody around initial and pre-release risk assessment which were lacking at the time. In particular, all detainees should now be subject to self-assessment and officer assessment of their health, safety and well-being and asked whether they wish to be contacted by an independent alcohol referral scheme worker. Likewise, pre-release risk assessments have since been made mandatory to identify risks to detainees arising from issues such as alcohol and to offer referrals to agencies where concerns arise. This is accompanied by a referral leaflet featuring details of organisations available for help or advice on issues such as domestic abuse, addiction and financial concerns, all of which would have been relevant to the victim.

83. Whilst not directly related to David's abuse of Susan, Susan's relationship with one of her adult daughters, involved significant violence from both parties in 2011. On a later incident reported in 2013, the police did not enter a Pre-Assessment Checklist (PAC) on the system for recording child protection information and notification forms for children and young people, known as MERLIN. Likewise, first responders did not uncover former incidents of grievous bodily harm between the two, as would have been expected of intelligence checks at the time, although this was uncovered by specialists thereafter.

84. In respect of the completion, supervision and referral of child safeguarding (MERLIN PAC) reports, there has been an overhaul of Standard Operating Procedures to produce checklists of mandatory actions which includes the completion of MERLIN reports.

85. The victim's eldest daughter was clearly frustrated by delays in the police response on the evening that her mother was found. The panel heard how the delays themselves were unavoidable, as there had been significant serious incidents that were drawing heavily on police resources at the same time. Nonetheless, it was evident that the individual had been dissuaded from making a missing person's report earlier that evening as a result of the threat of the police breaking her mother's door down and potentially leaving the property vulnerable.

86. Police noted that their policy around custody checks has since been reviewed and new guidance implemented in January 2016. This enables operators to conduct Metropolitan Police Service (MPS) wide custody checks on behalf of a concerned caller rather than requesting that members of the public do it themselves. Had this been in place at the time, a Missing Person enquiry could have been initiated earlier that evening. This would have not impacted upon the victim's death which was thought to have occurred days earlier. However, it is unknown if entering the property earlier would have had any effect on the perpetrator's state of mind.

87. In respect of the process by which the police decided on breaking into the victim's flat on the evening, the Metropolitan Police IMR author provided an analysis of the powers available to them under Section 17(1) (e) Police and Criminal Evidence Act 1984. Under these powers, a constable may enter and search any premises for the purpose of "saving life or limb". However, case law has determined that concern for welfare alone was not sufficient to justify entry (Syed v DPP, 2010). The IMR author considered that it was therefore important, given the court's interpretation of the legislation, that officers gather as much information as possible in support of their grounds for entry. This might include speaking with occupants, neighbours or collating any other information or intelligence to support an honestly held belief that entry without warrant is necessary. In this way, the officers appeared to have exercised their duties responsibly, given the information that they would have known at the time.

88. As the omissions in the police responses are mainly historic and have each been superseded by developments in policies and practice since these times, the Metropolitan Police have already made improvements in their responses. However, the review has recommended that evidence should be provided to the Community Safety Partnership of improved responses to domestic abuse and child safeguarding, including compliance with DASH and the introduction of Domestic Abuse Matters programme of training for first responders and their supervisors; accurate crime recording of domestic abuse; improved referral to substance misuse treatment services ; compliance with risk assessment post custody and compliance with renewed procedures on child safeguarding and protection.

4.2 Primary and Acute Heath Care

89. The review considered whether there had been any opportunity to address domestic abuse within the primary care setting. Both Susan and David were registered with the same GP practice but were not frequent attenders.

90. GP records contained no disclosures of domestic abuse or presentations to them which could be seen as potential indicators of abuse, as defined by the National Institute for Health and Care Excellence (NICE) (2016).

91. Susan's records did not feature any reference to alcohol mis-use nor a history of violence connected with alcohol use. However, it had been identified that David had been drinking 56 units of alcohol per week which is significantly above the 14 units per week guidelines of the Chief Medical Officer. By 2010, however, his records noted him to be an "ex-heavy drinker".

92. The GP records contained reports of earlier attendances at Emergency Departments: Susan attended Charing Cross Emergency Department in 2010 with a fracture to her foot; David experienced a fractured fibula in 2005 and attended Chelsea and Westminster Emergency Department in 2010. No context is known for any of these presentations. Since this time, Independent Domestic Violence Advisors have been located in these Emergency Departments and can ensure that enquiries around domestic abuse are routinely made.

93. It is expected that the GP would have oversight of a patient's attendances at Emergency Departments and if domestic abuse was a known feature their procedure would have been to follow this up, safely. However, domestic abuse was not a known feature of her presentation at the time.

94. The GP Practice was also asked to comment upon the impact of head injuries upon David's health and behaviour. Whilst David had been consistently treated for epilepsy, the GP records contained no reference to any brain damage or identified care and support needs requiring any specific referral.

95. The local area has since adopted the Identification and Referral to Improve Safety (IRIS) programme as part of its whole health approach to domestic abuse across acute and community health services. This programme is known as a pathfinder and supported by a consortium of specialist domestic abuse agencies including Standing Together Against Domestic Violence, Safe Lives, Imkaan and AVA.

96. In respect of the primary care element of this pathfinder programme, IRIS is a general practice-based, domestic abuse, training, support and referral programme which seeks to provide a skilled, care pathway for domestic abuse and is planned to be delivered to forty two primary care practices including the practice concerned in this case. The programme recruits a clinical champion from each practice and delivers training, electronic prompts

for clinical enquiry, care pathways and an enhanced referral pathway to specialist domestic violence services.

4.3 Adult Social Care

97. Susan received a carers assessment from Adult Social Care after she alerted them to her role of caring for her elderly friend and neighbour who had dementia and was housebound. No domestic abuse was disclosed during the telephone assessment and Adult Social Care did not identify any prompts or indicators that would have led to making direct enquiries over domestic abuse. Neither were there any indications that Susan had problems with alcohol.

98. Carer's grants were described as one-off payments to support an informal carer in their caring role. In order to explore her longer-term financial needs and entitlement to welfare benefits, Susan was referred to Income Maximisation. No issues of debt or economic abuse were recorded in this regard at this time, although it is not evident that domestic abuse and economic abuse form part of these assessments. Adult Social Care have therefore made recommendations for themselves to write into their contracts for the providers of income maximisation, routine enquiry on domestic abuse and to include routine enquiry in the Carers Assessment template that social workers use.

99. Adult Social Care reported no doubts as to Susan's suitability to support her friend and neighbour. Beyond financial needs, the carer's assessment did not identify any other carer's needs that needed to be addressed

100. However, records could not account for the delay in undertaking a review of the assessment the following year or why, when the review was undertaken late, it was not completed. Further enquiries at this time, three months before the deaths, may have revealed that Susan was in debt or subject to economic abuse: exploring whether David was coercing her into debt or controlling her money and resources.

101. Adult Social Care advised that the target for the proportion of known carers who have been assessed or reviewed has been 95% for 2018-20. For the previous full year, 2018-19, 93% of reviews were assessed or reviewed in this way and the review was advised that performance is being monitored and improved as a result. Adult Social Care will therefore provide the Community Safety Partnership with evidence of their improvement in meeting these targets over the current year.

4.4 Royal Borough of Kensington and Chelsea Housing Management

102. Management of the former Tenancy Management Organisation, along with their tenancy records, has transferred to the local authority in the period since the deaths. The previous records were sparse, particularly as the rent account had been in credit for several years and no anti-social behaviour or nuisance was recorded. No routine tenancy

checks appeared to have been undertaken, although it was noted that the recording system was rudimentary and may not have recorded every intervention that had been made. Neither was it possible to interview the housing management staff who were involved at the time as none were still working in the area.

103. Nevertheless, the Royal Borough of Kensington and Chelsea advised that, since management of the properties had returned to them, improvements are being made to ensure that all residents are visited to ensure that any vulnerabilities are identified, and a channel of communication opened by which residents can report matters of concern. However, in view of the shortcomings of the prior arrangements, a recommendation has been made for Housing Services to consider joining the Domestic Abuse Housing Alliance to provide support to the process of improving responses to domestic abuse. The Domestic Abuse Housing Alliance's (DAHA) is a partnership between three agencies to address domestic abuse within housing; Standing Together Against Domestic Violence (STADV), Peabody and Gentoo and has established the first accreditation for housing providers.

4.5 Children's Services

104. Although the amount of time that has elapsed since the children were subject to safeguarding and child protection proceedings, has made it unreasonable to attempt to analyse historic social care practice, the panel nonetheless considered it important to be able to demonstrate that processes responding to domestic abuse in child safeguarding are now more robust. Indeed, since this time, domestic abuse has become a priority for the Safeguarding Children Board and the expectations and responses to domestic abuse in the Children's Services, have been shown to have improved significantly. Safeguarding Audits conducted under Section 175 of the Children Act 2004, have revealed in particular, an improvement in conference plans and holding the perpetrator accountable.

105. The local area has more recently adopted the Safe and Together model of working in domestic abuse which place emphasis on the authority partnering with the non-abusing parent and intervening with the perpetrator.

> "This child-centred model derives its name from the concept that children are best served when we can work toward keeping them safe and together with the non-offending parent (the adult domestic violence survivor). The Model provides a framework for partnering with domestic violence survivors and intervening with domestic violence perpetrators" (Safe and Together Institute)[8]

106. In this way, Children's Services and their partners, can be seen to be adopting a particularly child-and-woman focussed model of intervention in domestic abuse. The model has been applauded for debunking the damaging 'failing to protect' narrative that has been dominant in child protection practice nationally and, which traditionally

[8] Further details are available at https://safeandtogetherinstitute.com/

has held the non-abusing parent, usually the mother, solely accountable for protecting her children from an abuser and the abuser has remained invisible to services. Had the Safe and Together model been applied to Susan's family at that time, Susan's alcohol dependency would likely have been viewed as a coping strategy for the abuse she was experiencing, rather than a threat to the children, and the authority would have instead taken action to protect her and the children from their abuser, whilst working in partnership with her to support her parenting and needs.

5. THEMATIC ANALYSIS, LEARNING & RECOMMENDATIONS

5.1 Awareness of domestic violence and abuse

107. A key function of domestic homicide reviews is to contribute to a better understanding of domestic abuse (Section 7, Multi-Agency Statutory Guidance, 2016).

108. Susan experienced domestic abuse during both of the long-term relationships in which her children were born. In this way, she will have had to raise each of her three daughters in households blighted by their fathers' domestic abuse. Although Susan's children were subject to child protection proceedings for significant periods in their childhoods, neither fathers' domestic abuse appeared to have been identified or addressed by agencies. Indeed, it does not appear to be until the end of her earlier marriage that Susan disclosed her experiences of abuse and, not uncommonly, she appeared to have declined attempts made to refer her to domestic abuse agencies thereafter. These early experiences, whilst outside of the scope of this review, provide a context for Susan's engagement with agencies thereafter.

109. The review has been able to establish that, in more recent years, only the police appear to have been aware of domestic abuse within the relationship from Susan's earlier reports to them in 2004. The only incident which might have been an indicator of domestic abuse was in 2010 when Susan attended the Urgent Care Centre. She explained that she had fallen downstairs. As David attended the appointment with her, there would have unlikely been an opportunity for routine enquiry in this circumstance. We have seen the Independent Domestic Violence Advisors are now located in acute health settings in the borough.

110. When Susan reported domestic abuse to the police, David went on to make counter-allegations and appeared to have been trying to undermine Susan's credibility and cast doubt upon her testimonies. This type of behaviour demonstrates how perpetrators can seek to distort the perspective of professionals as well as their victims. Counter-allegations need to be viewed through the prism of coercive control and it was to the police's credit that the perpetrator's counter-allegations did not appear to divert them from their course of investigating the crimes.

111. Although agencies had little awareness of domestic abuse, we have seen that neighbours provided witness statements that they had heard banging, shouting and screaming coming from Susan's flat during the month before her death. It is not unusual for neighbours and other members of the community to be alarmed by such observations and not feel confident to take action. It could be said that aspects of a widespread culture still dominate and that this culture prioritises the need to respect the privacy of other people's personal lives. In doing so, it creates a barrier which prevents individuals from intervening in a range of settings when they suspect abuse may be happening.

112. At the same time, Susan herself did not appear to have sought help during this apparent escalation of abuse. Moreover, family members later advised the police that they had not been aware of David's domestic abuse and they considered Susan and David to have a loving relationship. They advised that they had witnessed arguments but commented that they had not witnessed any physical assaults.

113. Local areas need to persevere in raising public awareness about domestic abuse and how to respond. Public awareness needs to be aimed not only at victims and perpetrators but also aimed at local communities, families, friends and neighbours. It especially needs to challenge this dominant culture of privacy that contributes to the secrecy of domestic abuse. The local population need to be alerted to the various characteristics of domestic abuse, including physical violence and coercive control, and how they can respond safely.

Learning Points: Understanding Domestic Abuse

- Health practitioners need to be alert to opportunities for routine enquiry into domestic abuse
- Perpetrators often make counter-allegations and seek to undermine their victim's credibility. Counter-allegations should be seen through the prism of coercive control.
- Local communities, family, friends and neighbours need to be enabled to act when they suspect domestic abuse and more public awareness of how they can act safely needs to be delivered.

Recommendation 1: Raising public awareness of how to respond to domestic abuse

Safer Kensington and Chelsea Partnership should continue to undertake awareness raising targeting local communities, family, friends and neighbours:

- Distinguishing the different forms of domestic abuse and coercive control
- Guiding them on how to take action when they suspect abuse

Recommendation 2: Safe Enquiry

Safer Kensington and Chelsea Partnership should seek assurance from health agencies that they have procedures and pathways to enable safe enquiry in domestic abuse when indicators of abuse exist.

5.2 Alcohol misuse and domestic abuse

114. The compounding effects of repeated or sustained domestic abuse should not be under-estimated. For example, women who have experienced domestic and sexual abuse are far more likely to be substance dependent than those who have not. Findings from research vary on the degree to which this is more likely: Rees (2011) indicated that they would be three times more likely but earlier research by Stark and Flitcraft (1996) indicated that they could be as high as fifteen times more likely to be substance dependent that women who have not been abused. Moreover, research has further indicated that one third of women who have experienced domestic and sexual abuse over the life course will have an alcohol problem (Scott and MacManus, 2016). In this way, women will often use alcohol as a means to cope with the domestic and sexual abuse that they have experienced. Therefore, whilst the period that Susan's alcohol use first became problematic is not specifically known, it is not surprising that Susan experienced long-term problems with alcohol use after repeated and sustained experiences of domestic abuse.

115. Susan had little contact with agencies in recent years. However, since reporting domestic abuse in 2004, the police contact that she did have thereafter, mainly involved her alcohol misuse and violence or offensive behaviour to other people, but not to David. We have seen that the Metropolitan Police have made significant improvements in how they respond to offenders with alcohol problems, including the use of alcohol arrest referral schemes, which Susan may have benefitted from. However, if Susan's alcohol misuse was a coping strategy for current or 'historic' domestic abuse, it may well have been hard for her to consider losing this coping mechanism. For this reason, practitioners need to be mindful of this important relationship between domestic abuse and alcohol and frame how they engage with women who present with either issue in order to overcome the barriers and stigma that they may face.

116. Expert guidance has consistently advised that practitioners should routinely enquire about domestic abuse when alcohol is a known feature of a woman's life and require practitioners to be professionally curious about the social context of women's alcohol misuse (AVA, 2002; 2007). Research indicates that this is significantly more so for women than for men (AVA and Agenda, 2019). Indeed, the Metropolitan Police had records of Susan's earlier reports of domestic abuse and so were the only agency that knew that both factors existed for Susan in her relationship with David. Moreover, when Susan was routinely asked about her consumption of alcohol by health agencies, she denied that it was problematic, and in doing so, regrettably provided no indicators of abuse from which clinicians could undertake routine enquiry.

117. Nevertheless, Alcohol Concern and AVA (2016) found that problematic alcohol use has been a relatively common feature in domestic homicide reviews. Their research concluded that there was a need for all front-line services to recognise the link between alcohol and domestic violence and to be able to routinely enquire about domestic abuse where alcohol is present. The research goes on to provide checklists for agencies in the requirements of practitioners and organisations in order for them to be competent in responding effectively to domestic abuse and problematic alcohol use (2016:35).

118. Further guidance recently produced by the National Commission on Domestic and Sexual Violence and Multiple Disadvantage alerts practitioners to the multiple social stigmas that women may face when they are experiencing challenges in their lives such as addiction, poverty and social class compounded by how they are treated by their abusers (AVA and Agenda, 2019). Underpinning their recommendations was a clear need for a trauma and gender informed understanding of abuse and multiple disadvantage rooted in being able to build a trusting relationship with informed and trained practitioners from a strengths based perspective. There was no evidence provided to this review that Susan had been enabled to access such services and her needs largely remained invisible to services. **Learning Points: Alcohol misuse and domestic abuse**

Learning Point: Alcohol misuse and domestic abuse

- Practitioners need to be aware of the compounding effects of long term and serial experiences of domestic abuse and recognise that victims may use alcohol as coping mechanism to deal with their experiences
- Practitioners need to be skilled in safe enquiry about domestic abuse when alcohol is a feature of a woman's presentation
- Practitioners need to be both trauma and gender informed when engaging with victims of domestic abuse who experience multiple disadvantage

Recommendation 3: Alcohol misuse and domestic abuse

Safer Kensington and Chelsea Partnership should promote models of working with domestic abuse or alcohol that are trauma and gender informed, strengths based and seek assurance from its member agencies that their services are:

- Making routine enquiry into domestic abuse where alcohol is a feature of a woman's presentation
- Effectively enabling women experiencing domestic abuse and alcohol misuse, to be able to access specialist services that are capable of addressing both issues

5.3 Economic abuse and debt

119. Although records have been sparse, the information that has been available to the review has indicated that David was controlling in the relationship and this has become most apparent in relation to economic abuse.

120. The panel considered the pressures that the couple were under as a result of the significant debts that were owed. This consideration was not given because these

pressures were seen as causing domestic violence and abuse, but because they may have contributed to Susan's inability to escape an abusive relationship, had she wanted to. They were seen to also contribute to the panel's understanding of economic abuse in the relationship

121. It was noteworthy that in 2011, Susan received a housing benefit payment totalling over £4000. This payment enabled her to remain in credit on her rent account, without any further payments of rent, until her death, four years later. To be in credit in this way, revealed that she must have paid rent that was not due, for a considerable period before 2011. Indeed, the absence of housing benefit that had been due, will have contributed to a long-term shortfall in her income.

122. It is not known whether the Tenancy Management Organisation, as her landlord, had notified her about her rent credit or whether she could have this credit refunded to her. She may have chosen not to seek a refund. However, had Susan accessed this credit, it could have provided the means by which to negotiate the repayment of other debts and avoid increasing debts that may have been spiralling with interest and charges.

123. There was no indication that Susan or David had received advice regarding the management of their debts, although Susan had been referred to Adult Social Care's Income Maximisation service when she applied for a carer's grant. However, the records here again were sparse, and did not indicate any concerns such as debt or economic abuse.

124. The review also considered the manner of debt collection. In the six days before their deaths, the couple received twenty-eight calls from Littlewoods own debt recovery services and a total of fifty-one calls within that final month.

125. The review therefore enquired into the debt recovery arrangement with Littlewoods who are on the Financial Services Register and are required to adhere to the Consumer Credit Sourcebook of the Financial Conduct Authority (FCA) which states:

> "A firm must not pressurise a customer:(1) to pay a debt in one single or very few repayments or in unreasonably large amounts, when to do so would have an adverse impact on the customer's financial circumstances; (2) to pay a debt within an unreasonably short period of time (*Consumer Credit sourcebook (CONC) 7.3.10)*[9]

126. Whilst Littlewoods considered that their actions complied with current regulations, the panel considered that the frequency and number of calls within the relatively short space of time could have been felt as harassing by the recipient. Rather than refer the matter to the Financial Conduct Authority, it has been recommended that the Chair of the Partnership encourages the company to improve its consideration of economic

[9] Available at https://www.handbook.fca.org.uk/handbook/CONC.pdf

abuse in partnership with the principal, specialist agency on this matter, Surviving Economic Abuse[10].

Recommendation 4: Responding to Economic Abuse
The Chair of Safer Kensington and Chelsea Partnership should liaise with Littlewoods and recommend that they work with Surviving Economic Abuse to improve their awareness of domestic abuse and effectiveness of their debt collection strategies when domestic abuse is involved.

127. Being in debt and not having enough money to get by, was certainly on David's mind when he wrote confessional letters to the police and to his daughter before he killed Susan and himself. In the letters, he spoke of having lost his job and having spent his redundancy money, although the panel observed that he would not have received any redundancy money as he had been dismissed. He disclosed being in debt with catalogue companies; not having enough money to eat; Susan going to be hungry; that Susan's mobile phone had been disconnected and that he had stolen and sold Susan's jewellery. He expressed concern that Susan would be "heartbroken" if she knew and that he "decided to kill … [them both] … rather than break her heart". The onset of Christmas and letting his family down also featured in these letters.

128. The letters are revealing. They indicate that David had hidden his loss of job from Susan and had accumulated debt, the majority of which was in Susan's name, to cover his lie. In this way, David could be seen as controlling the finances; plunging Susan into debt; stealing Susan's resources; controlling the family narrative before and after the deaths and being prepared to kill Susan rather than face the consequences of his abusive behaviour. Given the review's focus on social and economic inequality, it was evident that this was about how one person controls another irrespective of their household means.

Recommendation 5: Economic Abuse
Safer Kensington and Chelsea Partnership should ensure that its agencies are able to meet anticipated, incoming obligations arising from the Domestic Abuse Bill to respond to economic abuse effectively.

[10] Further information of Surviving Economic Abuse can be found at https://survivingeconomicabuse.org/

Safer Kensington and Chelsea Partnership should raise public awareness about the nature of economic abuse and the availability of specialist support to deal with income maximisation and debt.

5.4 Co-ordinated Community Response to Domestic Abuse

129. Much of Susan's contact with agencies, and disclosures of abuse, were when her children were younger. It has not been within the scope of this review to examine in detail much of this earlier experience. Individual and multi-agency working practices in response to domestic abuse have changed dramatically over the last two decades and are incomparable to earlier practices. However, Susan's future relationship and engagement with agencies may well have been affected by these earlier experiences when her children were subject to child protection and her alcohol misuse rather than the domestic abuse that she was experiencing, appeared to be the main focus of agency attention and there appeared to be shortcomings in how agencies worked together to safeguard Susan and her children. After 2004, she did not disclose domestic abuse again.

130. As the couple had had little recent contact with agencies, neither has it been possible or relevant to assess the effectiveness of the local, co-ordinated community response to domestic abuse at that time. Nevertheless, the progress that agencies have made since this time, as well as their individual recommendations or assurances each contribute to the collective response to domestic abuse in the borough and tri-borough to which it belongs.

6. CONCLUSION

131. This review has considered the history of domestic abuse that Susan experienced, firstly from her husband and secondly from David. The compounding effect of sustained and repeated domestic abuse and its likely consequences for Susan's long-term alcohol misuse have been considered further, particularly as, aside from periodic presentations to the police involving alcohol, Susan and her abuser had little contact with agencies. Attempts were made by agencies to signpost Susan to alcohol treatment services, and later to domestic abuse services, but without success. As a result, this review has called for greater awareness amongst practitioners of the need to respond through trauma and gender informed practice.

132. It is not known whether David continued to be physically violent to Susan at any time following her reports to the police in 2004. However, David, having already exerted physical violence, would have been able to sustain the threat of violence thereafter without the need to resort to actual violence. The review concluded that there were strong indications that David exercised control within the relationship, particularly in respect of economic abuse where he stole from and impoverished Susan, ran up debts in her name and left her hungry in the days before he killed her. The review has called for greater awareness of both economic abuse and debt advice within the local population and for agencies to prepare themselves for the much-anticipated statutory guidance on domestic abuse within which economic abuse will undoubtedly feature.

133. In the absence of more contact with agencies, the review was unable to comment upon the multi-agency, co-ordinated community response to domestic abuse. Whilst there was significant contact with agencies in earlier times when child protection was an issue, the shortcomings in practice at this time were beyond the scope of the review as domestic abuse responses and child safeguarding practice has changed so greatly in the intervening years. However, these early experiences will likely have formed the context for Susan's future engagement and her needs remained largely invisible to services thereafter.

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8. ACTION PLANS

DRAFTS FOR AMENDMENT/POPULATION

Recommendation 1: Raising public awareness of how to respond to domestic abuse
Safer Kensington and Chelsea Partnership should continue to undertake awareness raising targeting local communities, family, friends and neighbours:

- Distinguishing the different forms of domestic abuse and coercive control
- Guiding them on how to take action when they suspect abuse

	Action	Scope	Lead Agency	Desired Outcome	How will success be measured	Target Date	Completion date and outcome
1.1	Partners to attend key community events to raise awareness of domestic abuse. This includes at libraries, community centres and children's centres.	Local	VAWG Strategic Lead and VAWG Partnership	Communities understand the how to identify domestic abuse and take action when they suspect abuse.	Number of events attended. Increase in self-referrals to specialist services.	Mar 2020	
1.2	A programme of events to be organised as part of November 25th and 16 Days of Activism to raise awareness of domestic abuse, including a social media campaign.	Local	VAWG Strategic Lead and VAWG Partnership	Awareness is raised amongst communities and residents of domestic abuse and the role they play in ending it as part of a coordinated community response.	Numbers of people attending events. Number of retweets and shares of social media campaign. Increase in referrals to specialist services.	Nov 2020	

Recommendation 2: Safe Enquiry
Safer Kensington and Chelsea Partnership should seek assurance from health agencies that they have procedures and pathways to enable safe enquiry in domestic abuse when indicators of abuse exist.

	Action	Scope	Lead Agency	Desired Outcome	How will success be measured	Target Date	Completion date and outcome
2.1	Imperial will continue to increase awareness of domestic abuse through a robust flowchart, procedures and pathways already in place for clinical staff.	Local	Imperial	Patients/clients will feel safe within the hospital setting and be able to disclose more freely .	Increase of referrals to IDVAs and MARACs as applicable. Staff's training and competency at the correct levels to be maintained.	Apr 2020	
2.2	Imperial will work closely with safeguarding champions to ensure awareness of domestic abuse is raised amongst all hospital staff.	Local	Imperial	Staff are engaged and aware of their role in supporting those affected by domestic abuse.	Increase of referrals to IDVAs and MARACs as applicable. Staff's training and competency at the correct levels to be maintained. Engagement levels of the projects to be monitored.	Jul 2020	
2.3	CCG to support role out of the IRISi GP support programme and focus on its sustainability once funding ends in March 2020.	Local	WL CCG (Pathfinder Project)	GPs are trained to identify women affected by domestic abuse and to signpost on to support.	Improved confidence in making DVA enquiries. Referrals to DVA services.	Mar 2020	

Recommendation 3: Alcohol misuse and domestic abuse

Safer Kensington and Chelsea Partnership should promote models of working with domestic abuse or alcohol that are trauma and gender informed, strengths based and seek assurance from its member agencies that their services are:

- Making routine enquiry into domestic abuse where alcohol is a feature of a woman's presentation
- Effectively enabling women experiencing domestic abuse and alcohol misuse, to be able to access specialist services that are capable of addressing both issues

	Action	Scope	Lead Agency	Desired Outcome	How will success be measured	Target Date	Completion date and outcome
3.1	Imperial will continue working with the alcohol commissioned service to create a consistent clear process to support for domestic abuse through working with the CGL liaison service.	Local	Imperial /CGL	To ensure the processes and procedures are followed for the patients.	There will be continuing dialogue with CGL and potential audits of presentations to EDs/UCC	Sept 2020	
3.2	Imperial will continue with routine enquiry into domestic abuse in the Trust's Sexual Health and Maternity teams. Work will be undertaken to explore where routine enquiry can be introduced elsewhere in a patient's journey.	Local	Imperial	Patients experiencing domestic abuse are supported consistently across the trust.	A focus group will be held determine where else in the Trust prompts for routine enquiry can be included.	Sept 2020	
3.3	DAWS to set up a women's service to provide support for clients within the community who are affected by substance use and domestic abuse	Local	DAWS	Raise awareness of links between domestic abuse and substance use. To support more women in the community affected by domestic abuse and substance use. Women are signposted to support.	Number of women engaged with the support service. Number of women identified with support needs and referrals to specialist services.	Early 2020	

Recommendation 4: Responding to Economic Abuse

The Chair of Safer Kensington and Chelsea Partnership should write to Littlewoods and recommend that they work with Surviving Economic Abuse to improve their awareness of domestic abuse and effectiveness of their debt collection strategies when domestic abuse is involved.

	Action	Scope	Lead Agency	Desired Outcome	How will success be measured	Target Date	Completion date and outcome
4.1	The Chair of the Chair of Safer Kensington and Chelsea Partnership to write to Littlewoods and recommend that they work with Surviving Economic Abuse to improve their awareness of domestic abuse and effectiveness of their debt collection strategies when domestic abuse is involved.	National	Safer Kensington and Chelsea Partnership	Increased awareness of the prevalence and presentation of domestic abuse by Littlewood staff Improvements in the effectiveness of Littlewoods debt collection strategies when domestic abuse is involved.	Littlewoods and Surviving Economic Abuse to undertake joint working Training for Littlewood Debt Collection Agency teams	Nov 2019	

Recommendation 5: Economic Abuse

Safer Kensington and Chelsea Partnership should ensure that its agencies are able to meet anticipated, incoming obligations arising from the Domestic Abuse Bill to respond to economic abuse effectively.

Safer Kensington and Chelsea Partnership should raise public awareness about the nature of economic abuse and the availability of specialist support to deal with income maximisation and debt.

	Action	Scope	Lead Agency	Desired Outcome	How will success be measured	Target Date	Completion date and outcome

5.1	A learning event to be held for professionals that focuses on addressing the dynamics of domestic abuse, coercive control, economic abuse and how power works.	Local	Community Safety Team	To ensure that professionals are equipped to identify and respond to economic abuse, especially in light of recent changes in the law.	Number of attendees of learning event Feedback from evaluation forms Increase in referrals where economic abuse is identified	Dec 2019	
5.2	Annual VAWG conference in 2020 to focus on Economic Abuse.	Local	VAWG Partnership	Professionals are aware of changes in the law and understand their role in supporting survivors.	Number of attendees at the conference Increase in referrals where economic abuse is identified	Nov 2020	
5.3	Surviving Economic Abuse Pilot of Economic abuse support project to be delivered in RBKC.	Local	Angelou	SEA working with Angelou partners to increase awareness of and response to economic abuse	Safety plans including actions around economic abuse	Mar 2020	

7. Individual Agency Recommendations for Adult Social Care							
Recommendation: To ensure that contracted services undertaking income maximisation routinely enquire about economic abuse							
	Action	Scope	Lead Agency	Desired Outcome	How will success be measured?	Target Date	Completion Date
7.1	ASC to consider including a clause into existing contract specifications around enquiry into economic abuse	Local	ASC Commissioning	Awareness is raised at point of referral of economic abuse.	Contract specifications include details of enquiry into economic abuse.	Mar 2020	
Recommendation: To ensure that routine enquiry on domestic abuse is undertaken during carers assessments and reviews							

7.2	A reference to domestic abuse will be added to as a prompt in the Carers Assessment proforma used by staff.	Local	RBKC Adult Safeguarding	Staff are routinely asking about domestic abuse when assessing need.	Numbers of staff attending training Increase in referrals from ASC to services	Mar 2020	
Recommendation: To provide assurance to the Community Safety Partnership that targets for completion of carers assessments and reviews are met							
7.3	ASC to provide the CSPB with assurance that targets for completion of carers assessments and reviews are met through sharing Key Performance Indicators.	Local	RBKC Adult Safeguarding	CSPB are assured that ASC is meeting targets for completion of carers assessments.	A report is provided to the CSPB/ Increase in referrals from ASC to services.	Jan 2020	

8. Individual Agency Recommendations for Metropolitan Police

Recommendation: To provide assurance to the Community Safety Partnership that improvement has been made in domestic abuse and child safeguarding practice concerning:

- **Compliance with DASH**
- **Accurate crime recording of domestic abuse**
- **Improved referral to substance misuse treatment services**
- **Compliance with risk assessment post custody**
- **Compliance with renewed procedures on child safeguarding and protection**

	Action	**Scope**	**Lead Agency**	**Desired Outcome**	**How will success be measured**	**Target Date**	**Completion Date**
8.1	Domestic abuse audits regularly undertaken by dedicated teams on a thematic basis to assess effectiveness of safeguarding procedures.	CW BCU	CW BCU Team	Audits highlight gaps and offer assurance that safeguarding needs of survivors are met.	Improvement in processes from results of audits undertaken by dedicated inspection team.	Mar 2020 and on-going	

8.2	Regular internal BCU reviews focusing on improving domestic abuse response.	CW BCU	CW BCU Team	Reviews undertaken which ensure compliance with DASH and safeguarding procedures, accurate crime recording of domestic abuse, and improved referrals to services.	Number of reviews undertaken by the BCU. Findings from reviews and information shared with partners at the CSPB.	Mar 2020	

9. Individual Agency Recommendations for Children's Social Care							
Recommendation: To provide assurance to the Community Safety Partnership that improved practice in domestic abuse and child safeguarding practice has been made in the intervening years and that perpetrators are held accountable for their abuse.							
	Action	**Scope**	**Lead Agency**	**Desired Outcome**	**How will success be measured**	**Target Date**	**Completion Date**
9.1	Operation Encompass to continue to be delivered across RBKC to ensure schools are supported to support children affected by domestic abuse.	Regional	MPS, Safer Schools Police & DSL in Schools Forum.	Provision of support within the school environment to better safeguard children against the short, medium and long-term effects of domestic abuse.	Number of schools engaged in project. Number of children supported	March 2020	
9.2	An audit will be undertaken to determine the responses of children's services and multi-agency partners in the safeguarding and protection of children and victims of domestic abuse.	Local	LSCP	To ensure that children at risk are safeguarded against harm and abuse	A follow up audit after a period of time will determine impact of more focused work through adoption of the Safe and Together Model.	Early 2020	
9.3	Implementation of the Safe and Together Model across Children's Social Care.	Local	VAWG Partnership	Increase in professionals partnering with the non-abusive parent and holding the perpetrator to account	Improvements in practices identified in the follow up audit.	Nov 2020	

				to better safeguard children.			
9.4	Training on domestic abuse to be continued to be delivered to multi-agency staff.	Local	LSCP	Professionals are confident in identifying, supporting and signposting survivors.	Number of professionals attending training.	Ongoing	

10. Individual Agency Recommendations for Housing Services							
Recommendation: To consider strengthening the approach to domestic abuse by joining the Domestic Abuse Housing Alliance (DAHA)							
	Action	Scope	Lead Agency	Desired Outcome	How will success be measured	Target Date	Completion Date
10.1	RBKC Housing Services to sign up to DAHA Accreditation	Local	RBKC Housing Services	Robust response to domestic abuse within housing management	Completion of the DAHA process Audit results of DAHA accreditation	Mar 2020	
10.2	Continue to support the roll out of the 'Whole Housing Project' and focus on its sustainability once funding ends in March 2020.	Local	RBKC Housing Services and VAWG Partnership	All agencies within the wider housing sector are aware of the role they play in ending domestic abuse as part of a coordinated community response.	Creation of best practice toolkit for housing professionals to respond to c abuse. Additional funding secured to continue the project.	Mar 2020	