CASTLE POINT COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW OVERVIEW REPORT

Case of Olivia, March 2018

DHR Chair and Report Author: Althea Cribb

DHR Executive Summary completed: October 2019

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1. THE DHR PROCESS

1.1. This summary outlines the process undertaken by Castle Point Community Safety Partnership Domestic Homicide Review Panel in reviewing the homicide of Olivia, a resident in their area.

1.2. The following pseudonyms have been used in this review for the victim and perpetrator to protect their identities and those of their family members: Olivia, victim, aged 72; Harry, perpetrator, aged 50. Both were recorded as white European ethnicity.

1.3. Olivia was killed by her former son-in-law, Harry, in her home. Harry took his own life at the incident. The outcome of the coroner's inquest was as follows:

- Olivia: unlawful killing with narrative
- Harry: suicide with narrative

1.4. The narrative was: "Olivia's and Harry's deaths were as a result of the following contributing factors:

- Inaccuracy and lack of detail in Statutory Authority Databases.
- Information not completed or reviewed in a timely manner.
- Risks posed by Harry continually not assessed.
- Arrest attempts not carried out in a timely and efficient manner.
- Lack of efficient cooperation between Police Departments and other agencies, through poorly defined areas of responsibilities."

1.5. The process began with an initial meeting of the Southend, Essex and Thurrock Domestic Homicide Review Core Group in April 2018 when the decision to hold a Domestic Homicide Review was agreed.

1.6. All agencies that potentially had contact with Olivia and/or Harry prior to the point of death were contacted and asked to confirm whether they were involved with them. Five agencies confirmed contact with Olivia and/or Harry and were asked to secure their files, and subsequently to produce Individual Management Reviews (IMRs) and chronologies. IMR authors were independent of the case and line management of those involved with Olivia or Harry.

1.7. Due to contact with Harry shortly before the incident, the case was referred by Essex Police to the Independent Office of Police Conduct (IOPC). The police contacts covered by the investigation were the only involvement of Essex Police. It was agreed therefore to put the DHR on hold until the IOPC investigation was completed. The final report was provided to the DHR in February 2019; the investigation concluded with no further action with regard to the individual officers, but learning for Essex Police that is being taken forward. The DHR was then completed as quickly as possible, while allowing time for family members to participate.

2. CONTRIBUTORS TO THE DHR

2.1 The following agencies contributed to the DHR:

Agency	Submission made
Castle Point and Rochford Clinical Commissioning Group On behalf of the two General Practices	Two IMRs and chronologies
Essex Partnership University Foundation NHS Trust	IMR and chronology
Essex Police	IMR and chronology
Open Road	IMR and chronology
Victim Support	IMR and chronology

3. INVOLVEMENT OF FAMILY

3.1 The independent chair liaised with the Essex Police Family Liaison Officers to understand the family composition, bearing in mind that the family of Olivia was also part of the family of Harry (albeit separated). A letter was sent from the independent chair to Olivia's family and to Harry's family. These were sent via the Family Liaison Officers, to ensure that their contact details remained confidential.

3.2 The letter made clear that involvement in the DHR was voluntary, and could happen in a way and at a time of the family members' choosing. The Home Office leaflet on DHRs was provided, along with information about the advocacy and support service provided by Advocacy After Fatal Domestic Abuse (AAFDA). The letter outlined the different ways in which family members could be involved in the DHR.

3.3 The independent chair was in contact with the families and they were involved to the extent to which they wished.

4. THE DHR PANEL MEMBERS

4.1. The DHR Panel comprised:

- Althea Cribb, Independent DHR Chair
- Alison Bird, Service Director, Changing Pathways
- David Padgett, Contract Accounts Manager, Victim Support
- DI Alison Hooper, Essex Police
- Melanie Harris, Castle Point Council and Community Safety Partnership
- Joni Thompson, Quality and Treatment Manager, Open Road
- Michelle Williams, Southend Essex and Thurrock Domestic Abuse Coordinator, SET Domestic Abuse Board, Essex County Council
- Tendayi Musundire, Head of Safeguarding, Essex Partnership University Foundation NHS Trust (EPUT)
- Yvonne Shaw, Associate Designated Nurse – Safeguarding, Castle Point and Rochford Clinical Commissioning Group

4.2. The process involved the independent chair agreeing the Terms of Reference, via email, with the SET DHR Team and the agencies involved in the case. One DHR Panel meeting was held to discuss the combined chronology, Individual Management Reviews and agree the learning in the case. The independent chair then wrote the Overview Report. This was circulated to the Panel and comments and amendments received via email; an updated report was sent to the DHR Panel and CSP for final signoff.

5. INDEPENDENT CHAIR AND REPORT AUTHOR

5.1 The Chair of the DHR and report author was Althea Cribb. Althea has been carrying out Domestic Homicide Reviews for six years and has completed eighteen reviews to date.

5.2 Althea received Domestic Homicide Review Chair training from Standing Together Against Domestic Violence, a national charity bringing communities together to end domestic abuse.

5.3 Althea Cribb has no connection with the Castle Point Community Safety Partnership.

6. TERMS OF REFERENCE FOR THE DHR

6.1 The key issues for the DHR were:

- Protected characteristics/additional vulnerabilities of Olivia: sex/gender; age; mental health.
- Protected characteristics/additional vulnerabilities of Harry: marital status; mental health.
- Recognition of and response to domestic abuse, separation and risk posed by Harry.
- Recognition of and response to victims of domestic abuse.

6.2 Agencies completing IMRs are required to analyse these issues in relation to their contact with Olivia and/or Harry, with specific reference to:

- The policies, procedures and guidelines providing the framework for the agency's response to the above issues.
- The training available to, and accessed by, staff in relation to responding to the above issues.
- What communication took place between agencies in relation to the above issues; the effectiveness and timeliness of this; the quality and outcomes of the communication.

7. SUMMARY

7.1. No agency had contact with both Olivia and Harry with the exception of the Improving Access to Psychological Therapies (IAPT) service, but this contact was separate, and there was no way (nor reason) at that time for them to know that they were connected.

7.2. From May 2016 to the date of her death, Olivia was in contact with her General Practice (GP) and the Essex Partnership University Foundation Trust (EPUT) mental health services in relation to anxiety and depression, and the impact of her husband's death (and briefly with Priory Group). In 2016 she was recorded as having concerns with regard to her son-in-law (Harry) in relation to him being "addicted to cocaine" and at the end of his marriage. These issues were raised in the context of Olivia needing support; at no time did she report that she was in fear and no abuse was reported. A call to police in the early hours of the morning on

which the incident occurred suggested concerns for Olivia in relation to Harry's behaviour; this was being responded to when the homicide occurred.

7.3. In 2014 and 2015 Harry had contact with his GP with regard to his mental health, specifically depression and anti-depressant medication for this. In 2015 he also referred to his cocaine use (or that he was "clean"). He referred to relationship separation, low self-esteem but no suicidal thoughts. In January 2016 he attended his GP again with regard to the same issues (but not his relationship). In October and November 2016 Harry attended his GP with low mood, and also attended Open Road drug and alcohol service for an assessment, support groups and one-to-one appointments. Later in November 2016 and through to January 2017 Harry attended his GP for medication reviews and was recorded as doing well. He stopped attending Open Road in November 2016. In February 2017 Harry again attended his GP with regard to his anti-depressant medication; this was his last attendance. Open Road continued to try to contact Harry but he did not respond or attend again. Harry had no further contact with agencies until January 2018 when he was arrested and charged by Essex Police for a domestic related offence (criminal damage). Following this Harry called police and reported he had attempted to take his own life; he was assessed by the Street Triage Team and he agreed he would see his GP. Harry was placed on bail following the offence, with conditions not to contact the victim of the incident or enter their road. In early March police were called six times to report harassment by Harry and breaches of bail conditions, but he was not arrested. The last call, which police were in the process of responding to, came in the early hours of the morning before the homicide.

8. KEY ISSUES ARISING FROM THE DHR

8.1. *Olivia's General Practice*: Olivia attended her GP twice in the Terms of Reference timeframe for the DHR. These attendances were a year apart but were similar in content, concerning Olivia's mental health needs. Although Olivia referred to issues relating to her son-in-law Harry, she did not report anything of any concern or risk to herself.

8.2. *Harry's General Practice*: Harry had extensive contact with his GP in the Terms of Reference timeframe; the last contact was a year prior to the homicide. All contact concerned his mental health, and his presentations fluctuated between feeling low and feeling better. The GP appropriately questioned Harry about his mental health and specifically about any suicidal thoughts. The IMR concluded that the GPs should have shown a more 'think family' approach when Harry disclosed mental health issues and substance misuse. Since the DHR, the Practice has taken a number of actions to improve responses to complex cases and to domestic abuse, including the introduction of Multidisciplinary Safeguarding Meetings to discuss these cases.

8.3. *Essex Partnership University Foundation NHS Trust (EPUT), Olivia*: The IAPT[1] provision had contact with Olivia and Harry at the same time but there was no way for that service to make a link between the two, and nothing in Olivia's and Harry's presentations that would have

[1] A brief intervention service delivering National Institute for Clinical Excellence (NICE) approved talking therapies for people with mild to moderate (up to but not including severe) symptoms of anxiety and depression, including other common mental health conditions.

prompted any further action. Olivia's risk assessments, care plans and reviews were carried out in accordance with Care Programme Approach Policy and transitions between teams were managed smoothly.

8.4. *Essex Partnership University Foundation NHS Trust (EPUT), Harry*: Harry accessed couples counselling with IAPT, at the end of which he transitioned to IAPT individual counselling. The DHR Panel discussed the potential inappropriateness of couples counselling when domestic abuse has been disclosed, as was the case with Harry. It should not be approached without a thorough assessment with each individual separately to ensure that potential domestic abuse victims have the opportunity to disclose what is going on for them. A recommendation is made for IAPT to review its approach in light of this learning.

8.5. *Essex Police*: Contact with Harry was from January to March 2018, concerning domestic related offences. These offences were flagged as domestic due to the relationship (former partners), and appropriately triggered responses within those policies and procedures. In addition to this the criminal offence of stalking should have been identified and responded to. The IMR also identified the following learning:

- Failure to recognise and record further offences (other than breach of bail) during contact in the week prior to the homicide.
- Absence of proactive responses to breaches of bail and a lack of understanding of which officers should be responsible for this.
- Lack of proper checks in relation to firearms; albeit once this was checked, prompt action was taken.
- Failure to identify children within homes where offences took place.

8.6. Good practice was noted in relation to policies, procedures and training in place for officers and staff to understand and respond to domestic abuse and vulnerabilities. A Gold Group has been established, and meets monthly, to implement the IMR recommendations as well as those identified by the IOPC and the Coroner's Prevention of Future Death Notice. A new Police/Crown Prosecution Service Protocol has been issued in relation to stalking and Essex Police are working to incorporate this to practice, along with College of Policing learning material on stalking.

8.7. *Open Road*: A comprehensive assessment and risk assessment were conducted with Harry at the start of his contact with the service in 2016. They did not identify any risks to Harry himself or anyone around him, and no information was received from any other agencies that could have caused concern. There was a long delay between Harry missing an appointment and the attempted follow up. The IMR states that while this was not in line with policy they are confident that this policy is followed through quarterly clinical governance framework audits and annual case file audits.

8.8. *Victim Support*: The service was not able to establish contact in response to automated referrals from Essex Police following the incidents reported. Procedures have now changed to allow more flexibility in contacts being made, and to ensure that all referrals that cannot be contacted are routinely fed back to officers.

8.9. *Equality and Diversity*: The nine protected characteristics identified in the Equality Act 2010 were assessed for relevance to the DHR. The characteristics of age, disability and sex were discussed by the DHR, and the potential vulnerabilities of mental health and drug and alcohol, were analysed. Agencies responded appropriately to Olivia in relation to her age and her mental health. There were lessons to be learned (see paragraphs above and sections nine and ten) in relation to Harry's drug and alcohol use, and the issue of sex in relation to identification of and response to domestic abuse and stalking behaviours.

9. CONCLUSIONS

9.1. In January 2018 Harry was no longer in contact with the organisations (General Practice, EPUT and Open Road) from which he had previously sought support and did not return to them. His family told the DHR that his mood worsened at that time but they felt unable to support him and he did not speak to them about what was happening for him.

9.2. Olivia had extensive contact with mental health services (EPUT) in which good practice has been identified (section 8 above). During contact with EPUT and her GP she mentioned issues related to her son-in-law (Harry) but this was not her primary reason or concern for needing mental health support, and she did not report at any time feeling at risk from Harry. The services she was in contact with had no information that would have caused concerns for Olivia's safety until just before the incident; Olivia's family feel that more could have been done by police to safeguard all members of the family. Harry's family told the DHR that they could not understand why Harry had attacked Olivia, as they had always supported each other.

9.3. Harry's considerable contact with his GP, EPUT and Open Road occurred in 2016 and 2017, and ended a year before the incident. There was both good practice and lessons to be learned in relation to this contact (see section 8) but these agencies were not aware of the apparent change in Harry's behaviour that was evident to Essex Police – who in turn did not, and could not, have the background information formed by those agencies. The learning for Essex Police is outlined above (section 8) but misses one area which is their lack of identification of and response to Harry's stalking behaviours. This learning is set out in the next section.

10. LESSONS TO BE LEARNT

10.1. In addition to the individual agency learning the key theme from this DHR relates to the recognition of and response to stalking.

10.2. Harry's pattern of behaviour amounted to stalking and should have been identified and pursued as such by police. This could have led to more action in response to opportunities to hold Harry accountable for his behaviour and keep victims safe by taking their levels of fear into account. This was most obvious when police were called in the early hours of the day of the homicide, in which concerns were expressed for Olivia, who Harry was now also contacting.

10.3. There is a follow on from the DASH risk identification checklist that can be used in these cases, called the S-DASH. The use of this should be promoted through the actions set out

below. It would have helped to focus officers' attention on the person's level of fear and opened opportunities to appropriately support her and family members.

10.4. The DHR Panel heard that the Southend Essex and Thurrock Domestic Abuse Board (SET DAB) had previously identified the need for greater awareness of stalking behaviours and offences, as a result of which a campaign is being launched in 2019 specifically on this. The independent chair and DHR Panel asked the SET DHR Team to ensure that the learning from this DHR is incorporated into the development of that campaign.

10.5. SET DAB will hold a workshop with practitioners and managers working with families and perpetrators affected by domestic abuse to increase awareness and understanding of stalking, and to increase confidence in identifying and responding to it.

10.6. In addition to this work, SET DAB (in partnership with the Essex Safeguarding Children's Board and Adults Board) hold Learning from Reviews events encompassing learning from DHRs, Safeguarding Adult Reviews, Serious Case Reviews, Multi Agency Case Audits and Partnership Learning Reviews. A recommendation is made for the events planned for October 2019 to incorporate the learning from this DHR in relation to stalking and think family.

11. DHR RECOMMENDATIONS

11.1. The Domestic Abuse Strategic Development Group to ensure that training, communications and learning events incorporate the learning from this DHR in relation to: Think Family, and in relation to stalking. To include the actions outlined in the Suzy Lamplugh Stalking and Homicide Report (2017) that need to be taken to appropriately respond to stalking, and the use of the S-DASH.

11.2. The Essex Partnership University Foundation NHS Trust IAPT (Improved Access to Psychological Therapies) to review its domestic abuse policies and procedures in light of the learning outlined in this DHR, to ensure that practitioners routinely respond to disclosures by seeing potential victims/survivors alone, without their partner, to assess whether they are safe to continue with couples counselling.

11.3. Essex Police to report to the Domestic Abuse Strategic Development Group on the outcomes of the Gold Group activity in relation to the learning on this case, and to make a report to the Group on the progress being made towards an improved response to stalking six months following the completion of the DHR.