

Executive Summary

Domestic Homicide Review

Christopher/2011

Author: Greg Barry

Commissioned by:
Kent Community Safety Partnership
Medway Community Safety Partnership

Executive Summary

1. The Review Process

1.1 On 14th October 2011 a man was fatally stabbed by his ex-wife in her home in Kent. This is the executive summary of a Domestic Homicide Review (DHR) of that murder commissioned by the Kent Community Safety Partnership on 7TH November 2011. The main purpose of a DHR is to establish lessons to be learned by examining the way that individuals and organisations work to safeguard victims of domestic abuse. The review was conducted in accordance with the Domestic Violence, Crime and Victims Act 2004 and the statutory guidance.

1.2 The review was conducted by a multi-agency panel consisting of senior representatives of agencies from Kent and Medway who are involved in providing domestic abuse services. Representatives from the core agencies in Greenwich and Essex also sat on the panel. The review panel was independently chaired. The panel considered reports from some of the agencies that provided services to the family and an overview report was written by the Independent Chair and approved by the panel that met on four occasions.

1.3 The agencies involved in the review were:-

Crime Reduction Initiative (Kent) – CRI – Alcohol treatment service
Community Hospital in Kent
District Council in Kent – Housing Department
Domestic Abuse Service in Kent
Essex Children’s Social Care
Essex Police
Essex Women’s Aid
GP for Elizabeth – Kent
Her Majesty’s Prison Service
KCA UK (drug, alcohol and mental health services)
Kent Police
Kent Probation Trust
Medway NHS Foundation Trust
Metropolitan Police Service
NHS Essex Hospital Service NHS Trust
NHS North Essex (GP for Christopher, Elizabeth and Elaine 2009-2011)
NHS SE London (GP for Christopher 2009 – 2011)
North Essex Partnership NHS Foundation Trust
Open Road Essex – alcohol treatment service
Oxleas NHS Foundation Trust (mental health services Greenwich)
Royal Borough of Greenwich Children’s Service
Royal Borough of Greenwich Housing Directorate

- 1.4 In addition information was obtained from Birmingham and Solihull Mental Health Foundation Trust, Children and Family Court Advisory and Support Service (CAFCASS), Essex Victim Support, Kent Children's Social Care and Medway Children's Social Care. Some agencies no longer held information on the family such as London Probation Trust so they were unable to assist the review and some of the agencies that did provide information had destroyed some of the historic records. A number of other support organisations were identified that may have had contact with the family between 2003 and 2007 and a decision was made not to contact them as it was unlikely that they would have any additional information. The review was unable to obtain the complete GP records for both Elizabeth and Christopher; as a consequence this review is incomplete. Unfortunately a small number of agencies providing reports did not provide full details of contact and despite numerous attempts to obtain information they declined to continue involvement in the review.
- 1.5 The agencies provided chronological accounts of their contact with the offender, the victim and their children prior to the homicide. These reports also contained an analysis of the service provided; this was achieved by comparing what happened and what was expected in accordance with existing policy and good practice within that agency and on a cross agency basis. Some agencies also submitted recommendations for their own agency and where appropriate for multi-agency working based on the conclusions of their review.
- 1.6 This review examined services provided to the victim, the offender and their two children. The time period considered was 1st January 2002 until 14th October 2011.
- 1.7 Pseudonyms have been used to protect the identity of the family members.

2. Circumstances of the homicide

- 2.1 Christopher was thirty years old when he was murdered and had known Elizabeth since he was twenty years old. They were married in October 2001 soon after they met. They had two children. They lived in Greenwich between 2001 and 2009. They were divorced in 2009. In May 2009 Elizabeth and Elaine moved from Greenwich to Kent for a short while and then to Essex. At some point Christopher moved to Essex as well and lived with Elizabeth and Elaine. In November 2009 Christopher moved back to Greenwich. In addition he also lived in Birmingham around June 2009. He had suffered from mental ill health since 1999. It is believed he was diagnosed with suffering from bi-polar disorder however this cannot be confirmed. Christopher also had long term issues with alcohol and substance misuse.

- 2.2 Elizabeth was twenty eight years old at the time of the murder. She also had significant problems with alcohol misuse and had suffered with mental health issues since 2002.
- 2.3 Peter was nine years old at the time of the murder. He has lived with his paternal grandmother and her husband since 2007. Elaine was seven years old at the time of the murder. She was living with foster carers in Essex as she had been taken into Police Protection in August 2010 and was then accommodated by Essex Children's Social Care. Neither of the parents had custody of either of the children at the time of the homicide but they did have contact. In August 2011 a decision had been made to return Elaine to Elizabeth's care and Elaine had started to spend weekends with her mother.
- 2.4 At the time of the murder Elizabeth was living in privately rented accommodation in Kent where she had been living since April 2011 having moved from Essex. Christopher was privately renting accommodation in Greenwich. It is believed Christopher had been living with Elizabeth.
- 2.5 The relationship between Christopher and Elizabeth had always been affected by alcohol and violence. Elizabeth has stated that the first time Christopher was violent towards her was two weeks after the relationship had started. She became pregnant a month after they met. During the ten years they knew each other there was no significant length of time when there were not problems because of alcohol, drugs, violence, dishonesty, child care, mental health, money, housing or imprisonment. It has been impossible to track exactly when they were living together, and although they were divorced in 2009 they still maintained an on off relationship with each other even though they also had other relationships. Christopher never reported any assaults upon himself by Elizabeth however his family have said that she did assault him on a regular basis. The assaults and incidents were invariably alcohol related.
- 2.6 On 14th October 2011 Christopher was released on Home Detention Curfew (HDC) from prison to Elizabeth's address in Kent. During the afternoon and early evening of the same day both of them drank alcohol, and about 20:30 hours that day an argument ensued resulting in Elizabeth fatally stabbing Christopher with a kitchen knife.
- 2.7 She was arrested soon afterwards and was later charged with murder. In April 2012, after a trial at the crown court, Elizabeth was convicted of murder and was sentenced to life imprisonment with a recommendation that she serve at least twelve years before being eligible for parole.

3. Agency involvement

- 3.1 The first report to an agency of domestic abuse was in January 2002 within the first year of their relationship. Although the Metropolitan Police Service (MPS) had attended an incident in August 2001 when Christopher had damaged a trolley in a hospital in Greenwich as he was annoyed about the length of time it was taking for his pregnant partner (believed to be Elizabeth) to be seen.
- 3.2 The MPS attended nineteen domestic abuse incidents involving Christopher and Elizabeth between 2002 and 2009. Alcohol was a factor in many of the incidents and in all cases it would appear that Elizabeth was the victim. On six occasions allegations of assault were made and Christopher was arrested for three of these assaults and charged with two of them. In the vast majority of cases Elizabeth did not want to support a prosecution and declined to make a statement. Ten of the incidents occurred prior to September 2004 and so before the Metropolitan Police's policy of positive action. In the main the incidents were dealt with appropriately, although there were opportunities between 2007 and 2009 for the MPS to have referred Elizabeth to other agencies including Women's Aid and the local drop in centre for domestic abuse or floating support. Christopher was given a harassment warning on one occasion.
- 3.3 The MPS were consistent in identifying the children of the family and appropriately referred the incidents of domestic abuse to children's social care which has been the policy of the MPS since 2002. CSC in Greenwich have stated that not all of these notifications were received by them and it has not been possible because of the length of time since then to establish what happened to these notifications.
- 3.4 The MPS made appropriate utilisation of the risk assessment models SPECSS+ and DASH-RIC that were in use at the time. In the main the risk assessments were correctly used by the officers on initial attendance. However when specialist officers reviewed the grading they did not identify all of the previous history and so opportunities were missed to increase the grading. This would have allowed consideration for further work by the police and or other agencies with Elizabeth to protect her.
- 3.5 Greenwich Children's Social Services/Children's Social Care (CSS/CSC) had significant contact with Christopher, Elizabeth and their two children. When CSS first became involved in July 2002, they gathered information from agencies but they did not take any positive action to reduce the risk that Peter was exposed to and this response was inadequate to safeguard him. There were four referrals before Peter was protected when he was placed in voluntary foster care in late January 2003. During this time there were concerns about Elizabeth's mental health as well as four incidents of domestic abuse and concerns regarding alcohol misuse by both parents.

- 3.6 It was surprising that Peter's name was removed from the Greenwich Child Protection Register in January 2004 and that the un-born child's (Elaine) details were not placed on the Register, as there had been no significant improvement in the parenting ability of Elizabeth or Christopher. In addition, the failure of CSS to act in response to the domestic abuse incident just prior to Elaine's birth was poor practice. Following further child protection interventions Peter was made subject of care proceedings and was eventually placed with extended family members through the court process. Elaine remained in the care of her mother Elizabeth.
- 3.7 Greenwich Council Housing Service had extensive contact with this family for the duration of the time examined by this review for a number of reasons including domestic abuse. The contact they did have with both Elizabeth and Christopher was timely and appropriate in response to their needs and with sharing information with other agencies.
- 3.8 KCA (substance misuse services) had minimal contact with Christopher in 2005 when he was in prison and on his release. It has not been possible to retrieve the records regarding this contact.
- 3.9 Elizabeth had contact with the mental health services in Greenwich (Oxleas NHS Foundation Trust) between 2002 and 2009. Christopher had his first contact in 1999 although he had been referred to a child psychologist in 1994; he then had on and off contact until his death. It has not been possible to fully analyse the services provided as the report submitted by the trust did not provide detail of all contact, treatment and liaison with other agencies. They were aware of all the major issues in this family, particularly in 2008 when their specialist clinic carried out a Forensic Parenting Assessment commissioned by Greenwich CSC of both Elizabeth and Christopher in respect of care proceedings and assessment of risk to Elizabeth. It is unfortunate that this service did not fully participate in the DHR, as they were in a unique position where they could have engaged with Elizabeth and Christopher as a couple and worked with other agencies to try and address some of the issues. In 2009 the service's failure to liaise with professionals in Essex after Elizabeth left Greenwich was poor practice.
- 3.10 CAFCASS's role was limited to interviewing the family members in 2008 and 2009 in respect of civil law proceedings in regards to Peter and Elaine. They did not discover any new information regarding domestic abuse during these contacts.
- 3.11 Essex Police attended the first of twelve incidents involving Elizabeth in September 2009. Six of which were domestic abuse related and four involved Christopher and two involved a different partner. The majority of the calls involved consumption of alcohol. Their initial response to the incidents was timely and appropriate with risk assessments taking place

- and positive action. They informed Essex CSC and child health of the incidents of domestic abuse as a child was resident in the same household. This worked very effectively and if it had not been for this process the school nurse at Elaine's school would not have alerted Essex CSC regarding previous child protection concerns in Greenwich and a pattern of domestic abuse since they had moved to Essex.
- 3.12 Essex Police did miss an opportunity to consider referring Elizabeth to a Multi-Agency Risk Assessment Conference (MARAC) after the third incident of domestic abuse in four weeks in October 2009. Although only one of the incidents involved an assault, as the school nurse had identified a pattern the police could have obtained further information regarding this family by raising the case at a MARAC.
- 3.13 Essex Police did take decisive action to protect both Elizabeth and Elaine when they attended the domestic abuse incident on 9th August 2010 by arresting Christopher and removing Elaine. It was surprising that the Police Child Abuse Investigation Team agreed that Essex CSC should deal with the matter and not investigate it jointly as a Section 47 child protection investigation, as again this would have been an opportunity for both agencies to obtain a full history of this family and respond accordingly. The attending officer assessed the risk to Elizabeth as being high, however when it was reassessed by a specialist officer they concluded that the risk should be downgraded to medium. This was an opportunity missed to have referred the case to a MARAC.
- 3.14 At the time of their involvement in this case Essex CSC was in special measures. They were not aware that this family had moved into their area until September 2009 when they received the first of three notifications from Essex Police; they recorded the incidents as contacts and made the decision to take no further action. Consequently they did not identify the pattern of domestic abuse, or identify that Elaine had been subject to a child protection investigation when the family lived in Greenwich and did not take any action until the school nurse highlighted it.
- 3.15 A chronology of events in Elaine's life was never completed by Essex CSC which would have identified the complex history of this family. Attempts to obtain a full history regarding this family from Greenwich CSC were not followed up. A Core Assessment for Elaine was undertaken and a safeguarding agreement signed by Elizabeth was put into place.
- 3.16 Essex CSC became involved again with Elaine in August 2010 when she was taken into Police Protection and then accommodated by Essex CSC. Elaine remained in foster care and was living with foster carers at the time of the murder. Essex CSC did not inform Kent CSC that Elaine was having visiting contact with Elizabeth when she moved to Kent. In addition, the social worker did not make any contact with Kent Police to

enquire if anything was known regarding Elizabeth or anyone else connected with that address. These two actions are good practice and not doing them was a failing. This is significant as one of the reasons for Elaine coming into foster care was domestic abuse.

- 3.17 Essex CSC had planned to unify Elaine with her mother. The decision to return Elaine to Elizabeth's care was questionable as Essex CSC did not have all the information that was available to them if they had made checks with other agencies such as the police in Essex and Kent. At times the response by Essex CSC to safeguarding Elaine was not authoritative and did not evidence clear or reflective decision making. The entrenched relationship between Elizabeth and Christopher was not fully considered in the context of the systemic links between domestic abuse, drug and alcohol misuse and mental health difficulties.
- 3.18 The GP in Essex had contact with Elizabeth between September 2009 and November 2010 regarding her depression. The GP made appropriate referrals to the mental health services during that time. They did not appear to be aware of the significant domestic abuse history and there was no information about her alcohol misuse. Elizabeth did not attend ten appointments during this time and there was no record of any action to follow up why this was which was poor practice, especially as she was suffering from mental ill health and had a significant mental health history.
- 3.19 According to GP records in Essex Christopher reported he was a teetotaler. He was only seen twice by the GP in September and October 2009 with mental health issues and the GP made an appropriate referral to the psychiatric service.
- 3.20 This review has only considered a report regarding contact that Christopher had with a GP in Greenwich between 2009 and 2011. It has not been possible to obtain details of any GP contact prior to this time. During this time the GP had limited dealings with Christopher for his mental ill health, alcohol misuse and some physical ailments. The GP was never aware of his full history; however they made appropriate referrals to specialist services.
- 3.21 The school nurse in Essex acted very professionally in November 2009, when they identified that there had been three domestic abuse incidents between Elizabeth and Christopher where Elaine had been resident in the same household and the previous child protection issues in Greenwich. On identifying this they took positive action by asking Essex CSC what action they were going to take. Without this pro-activity Essex CSC would not have known about the child protection history regarding Elaine. This is evidence of the need and benefit of reviewing notes on new clients and then making appropriate judgements regarding safeguarding and liaison with other agencies.

- 3.22 The mental health services in Essex had dealings with both Elizabeth and Christopher. The contact with Christopher in 2009 was limited as he did not live in the area for very long and he made no attempt to engage with the service. Elizabeth had contact with the service for only four months in 2010 and during that time Elizabeth disclosed her mental health history but did not disclose her alcohol misuse. There is no record of the service making contact with the mental health service in Greenwich where Elizabeth had been a patient at various times since 2002. Accepting that Elizabeth did not fully engage with the service the professionals working with her were not aware of the history of this family and only responded to the matters presented to them. Elizabeth had minimal contact with Essex Women's Aid between September and November 2010 and they provided appropriate advice and support; after initial engagement Elizabeth then stopped contact which is not uncommon. The service could have followed up by a letter encouraging her to make contact however this would be an additional demand on a stretched service.
- 3.23 Open Road Essex (substance misuse services) had limited contact with Elizabeth between September 2010 and June 2011, however she did not fully engage other than attending for assessment and planning; she did not attend a number of appointments for counselling. They responded appropriately based on the limited information they were provided with by Elizabeth and they shared information with Essex CSC.
- 3.24 Kent Police first had dealings with Elizabeth in May 2003 when they dealt with a domestic abuse incident between Elizabeth and her sister. They did not make any enquiries regarding Peter who was on the Child Protection Register in Greenwich when they attended this incident. Both were drunk and had been fighting. This was poor practice. At the time it was not the policy of the police in Kent to refer incidents of domestic abuse to CSC if there were children in the household. This practice of informing CSC when children are in the household in domestic abuse cases came into place in 2011.
- 3.25 The next time Kent Police had contact was in September 2009 when they dealt with the first of two domestic abuse incidents involving Elizabeth and Christopher. They also dealt with two domestic abuse incidents between Elizabeth and another partner in April 2011 arresting the partner on one occasion. Most of the incidents involved alcohol misuse. The incidents were dealt with appropriately. Christopher was arrested twice by Kent Police in Kent for matters not related to domestic abuse. In August 2011 Elizabeth called Kent Police informing them that Christopher was refusing to leave her flat and that he was wanted by the police. When the police arrived they dealt with the matter as a wanted person and not as a domestic abuse incident which was an opportunity missed. According to the family Christopher had moved in with Elizabeth but no agency until this

- point were aware that this was the case; however Kent Police were unaware of the significant domestic abuse history between the two of them and the safeguarding issues regarding Elaine.
- 3.26 When Kent Police were notified of the release of Christopher from prison on HDC on the day of the murder it was dealt with appropriately, as there was no reason for them to take any action.
 - 3.27 The GP in Kent had several contacts with Elizabeth between May and October 2011 and saw her on the day of the murder. When she saw the GP it was either for a physical complaint or asking for assistance regarding her child custody case; she did not raise any concerns about her mental state. The surgery is innovative that it uses an alcohol use audit questionnaire at time of registration, although it appears Elizabeth under reported her alcohol use when completing it as the score did not require any intervention. This contradiction does not appear to have been identified by the GP when she later asked for medication to stop her alcohol craving.
 - 3.28 The GP did make enquiries with Elizabeth regarding her ex-partner presumably as a way of assessing risk. The surgery as a consequence of this review has identified that it did not have a policy regarding domestic abuse; as a result they are carrying out a review of their procedures to formulate and adopt a policy incorporating the Royal College of General Practitioners (RCGP) guidance on the GP's role published in June 2012.
 - 3.29 Elizabeth engaged with Crime Reduction Initiative (an alcohol treatment service) in Kent for an intensive three months treatment between June and September 2011. She always presented free of alcohol at both one to one and group sessions. The service had created a detailed and appropriate programme for her. They liaised with other agencies regarding Elizabeth's application to gain custody of Elaine.
 - 3.30 The women's domestic abuse support service in Kent only had involvement with Elizabeth between May and July 2011 and she only disclosed some of the issues in her life. The worker did attempt to obtain information from Essex CSC but did not follow this up when a telephone call was not responded to. As a consequence of this case they have now mandated that all cases that are new to the area will be followed up by contact with relevant agencies to ensure full risk assessments can take place.
 - 3.31 The local authority housing service in Kent had only one contact with Elizabeth just before she had moved to the area in March 2011 and was seeking help being re-housed as she said she was homeless through not paying her rent. She disclosed a history of domestic abuse and the situation regarding Elaine being in care. As Elizabeth did not make an

application for housing and was only seeking advice the service correctly did not make any enquiries with other agencies.

- 3.32 Her Majesty's Prison Service had dealings with Christopher throughout the period of this review, however all of the matters that he was sentenced for were not related to domestic abuse and in the main were for motoring offences and therefore he was never considered to be a risk to public safety. The prison service have acknowledged that the process for a presumptive HDC should not have been used in September 2011, as Christopher did have a previous conviction for assault that occurred in 2009 and so his case should have been considered by a board and approved by the Governor of the prison. That aside the panel concur with the prison service's view that Christopher would have in all probability still been released on HDC. There is currently no process for prison staff to access the information held by other agencies unless the prisoner has been deemed to be one who poses a risk. Based on his previous convictions and the other information available to the staff in the prison, he did not fit the criteria of posing a risk to others. Even if he could have been kept in prison for the duration of his sentence it is more than likely he would have resumed his relationship with Elizabeth. As far as can be established, this is the only recorded incident of a person being released on HDC that has then been the subject of a domestic homicide, although there is no requirement for such incidents to be collated by the Ministry of Justice.
- 3.33 Kent Probation Trust's role in this case was restricted to carrying out an assessment of the address provided by Christopher as to its suitability for the monitoring station for the electronic tag in September 2011. In addition the assessment considered the suitability of the premises for an offender to reside in terms of any risk he/she may pose to the residents or neighbours. In line with accepted practice this was carried out by way of a telephone conversation with Elizabeth. It is the practice of some probation officers to do background checks with local agencies to see if there is any indication there may be some risk in approving the address given. This is usually based on the person's previous convictions however these are not always available as they were not in this case. Even if the previous convictions had been available, then it is doubtful if there was anything that would have prompted the officer to carry out any additional checks. If the officer had carried out checks then in order to obtain a full picture of Christopher, he would have had to contact the three police forces and the two CSC departments as a minimum who were involved in this case. Bearing in mind the circumstances surrounding his conviction it is unlikely that the probation officer would have carried out this research.

- 3.34 There were five other domestic abuse incidents in London which involved Christopher with other partners or family members; in December 2006 Christopher was the victim of a serious assault by his girlfriend (not Elizabeth). Christopher was involved in a further fifty one incidents of which he was a witness or victim on thirteen occasions. He was arrested thirty times for non-domestic abuse matters. These incidents occurred in Greenwich, Essex and Kent
- 3.35 In addition to the domestic abuse incidents, Elizabeth came to notice of the police at least eleven times for offences including criminal damage, public order and assault. Prior to the murder Elizabeth was convicted/cautioned for six offences one of which was assault. These incidents occurred in Greenwich Essex and Kent. Elizabeth's violent behaviour had increased in the twelve months prior to the homicide.

4. Family involvement in the review

- 4.1 On completion of the trial at the crown court the victim's family was invited to contribute to the review and they provided additional information which has been incorporated into the overview report. On completion of the report the findings were shared with the family to enable them to comment on the contents of the report and these comments have been detailed in the overview report. The offender's family declined to participate in the review.

5. Conclusions

- 5.1 This review is probably the only time that the majority of the agencies that have been involved with this family have contributed to a single analysis of what was happening in this complex family. It is unfortunate that not all the agencies that had contact with this family could be identified to participate in this review and that some of those that did assist were unwilling to provide all of the information requested by the Community Safety Partnership (CSP) and the Independent Chair. As a consequence the complete history of what was known by agencies about this family has not been made available to this review. In particular the information from the GPs that treated Christopher and Elizabeth in Greenwich in the period prior to 2009 would have been beneficial. In addition information from the hospitals in Greenwich that provided services to the whole family may have provided relevant information to assist this review. This lack of participation by the agencies should be highlighted by the Kent CSP to the relevant CSPs in Greenwich and Essex.

- 5.2 The failure to share information is a recurring theme in reviews of both domestic homicides and child protection cases that have been carried out nationally. The importance of information sharing is highlighted in most policies and guidance and agencies continually fail to share information and continue to work with the rule of optimism. This review has highlighted the missed opportunities to share information.
- 5.3 All reviews are conducted with the benefit of hindsight and it is accepted that appropriate current practice does not allow all agencies to be automatically aware of information held by other organisations. However, there must come a time when one or more agencies, or a professional, realises that to work effectively with either a family, or single member of the family, they need to look back and scope widely to obtain the information that is available subject to the law and information sharing guidance. Other reviews have highlighted that professionals do not seek out the information, nor do they analyse sufficiently the information that is available to them both within their own organisation and from other agencies. Individuals and organisations still cite that the various laws and guidance prevents this when in fact it encourages it. This review has identified that none of the agencies involved had the full picture, either because they were only working with one member of the family and often only one of their issues such as alcohol consumption or mental health and not the person or family as a whole. This was often exacerbated that often neither of the adults disclosed all of their history and which agencies were involved. Also, and more importantly, they did not disclose the truth about the current status of their relationship which did make it difficult for agencies to protect them and their children. At times they denied that they had an alcohol problem, for example when Elizabeth registered with her new GP in Essex in 2009 she stated she was a social drinker and Christopher is recorded as being teetotal. In addition, with them moving between and within local authorities, it did not make it easy for professionals to establish the truth about the extent of the problems in this complex family. Each member of this family was vulnerable in some way from another member of the family. There was a need for all agencies to consider the family as a whole and work together with all of them to improve their quality of life.
- 5.4 In the ten years of their relationship Christopher, Elizabeth and their children had contact with over forty different services some of which were separate departments within an organisation. Several of those services were for matters other than domestic abuse or child protection. During those contacts they had dealings with many professionals, especially those services that had long term involvement such as housing and the mental health services in Greenwich.

- 5.5 The creation, maintenance and then regular analysis of a chronology by individual agencies, particularly in complex cases and those where families have been known to an agency for a long time, has been highlighted in other reviews as good practice. This process also assists in identifying which other agencies may be involved with the family and may have information to assist in any risk assessment. The failure to do this was particularly relevant to the questionable decision to return Elaine to Elizabeth's care just before the murder.
- 5.6 There is no national database that contains all details of an individual and which agencies have information regarding them. The majority of agencies hold information in silos, for example there is no integrated health database either nationally or within a local area. Therefore a department in a hospital treating a person may not be aware of another department who is also working with the same individual, as the departments are controlled by different trusts even though they are in the same building. It becomes even more difficult when families move to a new area as there can often be a delay in transferring records. An example of this is that in October and November 2009 the GP in Essex and mental health services in Essex were attempting to treat Christopher and at the same time he had registered with a different GP in Greenwich and the mental health services in Greenwich were treating him. Each police force also has separate databases, although the development of the Police National Database will address some of these issues. It is easier to obtain information once a person has been convicted although some of that information is limited as only basic detail appears on the Police National Computer. There is no offence of domestic violence/abuse and so the record will state that the conviction is, for example, an assault and the record will not include the detail of the victim. The tracking of victims is more problematic and would require contact with each force area that the victim has lived in to identify any previous police involvement.
- 5.7 The panel concluded that there could have been improvements to the risk assessment processes conducted by the Prison and Kent Probation Trust. However they carried out their roles in accordance with the current practices other than the oversight of the previous assault conviction; it is believed that Christopher would still have been released on HDC. If the prison had known of the significance of the address given and the history of the relationship with Elizabeth then they would not have approved the address, however this would not have prevented them getting together. The evidence obtained in this review and presented at the criminal trial confirmed that they intended to resume their relationship, and therefore the review panel concluded that domestic abuse would have continued to be a significant feature.

- 5.8 During the ten years of their relationship there were many examples of positive action taken by individuals, single agencies and agencies working together to protect each member of the family and also attempts to change the behaviour of Christopher and Elizabeth. As agencies' knowledge of domestic abuse has increased and the benefits of working together have been accepted so have responses improved and this can be seen in this case. In addition the numbers of agencies who take an active role in the prevention of domestic abuse has increased such as housing and GPs.
- 5.9 There are still improvements that can be made by more information sharing and joined up working. In cases where agencies are treating separate issues such as alcohol misuse and mental health, unless there is a MARAC, there is no mechanism for an agreed complimentary programme of treatment and there is the possibility of agencies unknowingly working against each other. In such cases the identification of a lead professional would benefit both the victim and the professionals involved.
- 5.10 The only process where a victim of domestic abuse is the focus of a multi-agency meeting is the MARAC and when they were established there was no agreed process of formally transferring information between them when a victim moved. A clear process was published in January 2011. Other meetings may discuss families where domestic abuse is occurring; however, the focus is usually on the children. The agencies at these strategy meetings or child protection case conferences only have a statutory responsibility for the children. Consequently the victim may not always receive the full services that are available. The MARACs do have criteria that have to be met for automatic consideration however there is always the option for a professional to use their professional judgement to refer a case to the MARAC.
- 5.11 Elizabeth and Christopher both had a history of failing to attend appointments which is not uncommon for individuals with mental health problems and substance misuse issues. In the main these were not followed up by agencies.
- 5.12 There was no concrete evidence that either Christopher or Elizabeth displayed any real desire to change their lifestyle.. Without that commitment and all the time they maintained a relationship it was highly unlikely that the risk of further violence would be reduced despite the involvement with agencies.
- 5.13 The period between May and September 2009 may have been a critical time for intervention as the relationship appeared to have ended, with Christopher moving to Birmingham and was on bail conditions not to have contact with Elizabeth. In addition it appeared that Elizabeth did not want

the relationship to resume as she moved to Kent and then to Essex. It was during this period that this case was the only time it was presented to a MARAC in Greenwich and although it was understandable why no actions were agreed as the parties had moved away; with hindsight it was a significant opportunity missed. When the relationship resumed in September 2009 it commenced on a downward spiral with violence, alcohol, drugs, mental ill health, suicidal thoughts/attempt, child protection issues, as well as a failure to attend appointments by both Elizabeth and Christopher. This continued into 2010 with a further significant assault occurring in August. This incident was another opportunity for the case to be presented to a MARAC and it was a poor decision by the police to down grade the risk assessment. All of the previous issues were still present and it would have been appropriate to have referred the case for a full multi-agency risk assessment and safety planning.

- 5.14 At the time of the murder in September 2011, the only organisations that knew Elizabeth and Christopher were intending to live as a couple and that they had resumed their relationship were the prison, Kent Probation Trust, the electronic monitoring company and Kent Police. It is accepted that Kent Police only knew this as part of an administrative process. However none of those agencies were aware of the full history of this family and the dangers that Elizabeth and Christopher posed to each other and to their children, especially when under the influence of alcohol or drugs. Therefore there is no criticism of them based on current practice which they adhered to.
- 5.15 The review panel was of the opinion that there was sufficient information available for agencies to have predicted that the domestic abuse would continue. It was also predictable that the consumption of alcohol was likely to precede any acts of violence.
- 5.16 The panel identified the following factors to support that conclusion:-
- There had been at least twenty five incidents of domestic abuse involving Elizabeth and Christopher that were reported to agencies.
 - There were other incidents of domestic abuse that were not reported.
 - Elizabeth and Christopher had been involved in other relationships where domestic abuse had occurred.
 - Elizabeth and Christopher suffered from mental ill health for a long time.
 - Elizabeth had a long history of serious alcohol misuse.

- Christopher had a long history of serious alcohol and drug misuse.
 - The incidents of domestic abuse had escalated from physical assaults to the use of knives.
 - Elizabeth had become more violent in the twelve months preceding the murder.
 - There had been at least two occasions where Elizabeth had possession of a knife during a domestic abuse incident.
 - Elizabeth and Christopher had difficulty in maintaining engagement with services and neither indicated any real commitment to change.
 - The relationship was not likely to end.
 - Christopher had made threats to kill Elizabeth.
 - There was tension over Elizabeth obtaining custody of Elaine as they both knew that it was partly dependent on their relationship not resuming.
 - Christopher and Elizabeth both had a criminal history.
 - There were financial problems; neither had ever been employed for any significant length of time and both had failed to pay housing rent in the past.
 - Elizabeth and Christopher had both had suicidal thoughts and Christopher had overdosed on one occasion as well as self-harming.
- 5.17 There was overwhelming evidence over the ten years that Elizabeth and Christopher had been together that the relationship had not ended; however some agencies and professionals did not appear to acknowledge this. All of the time that these two individuals maintained a relationship/contact in whatever form there was always going to be a risk of continued excessive alcohol consumption which invariably would lead to violence. The indicators of the co-dependency of Elizabeth and Christopher's relationship and the issue of separation sometimes heightening risk were not always understood.
- 5.18 The panel has concluded that the response by agencies to the child protection issues of both Peter and Elaine whilst they were living in Essex and Greenwich did not, on several occasions, gather all relevant information to enable a full risk assessment to take place; therefore they were exposed unnecessarily to continued violence between Elizabeth and

Christopher as well as when they had new partners. The lack of positive action on several occasions by CSC, police and health professionals was poor practice. Guidance within and between agencies was not followed and there were opportunities for agencies to have challenged the lack of decisive action by others.

- 5.19 The response to domestic abuse has changed considerably over the period of this review with far more multi agency working, for example the Metropolitan Police Service have automatically referred families to CSC where children were in the same household when a domestic abuse incident occurs since 2004. Other forces such as Kent Police have only done this since 2011 and then only in limited cases and only to CSC. They are currently in discussion with health on how best to roll this out. Essex Police have automatically informed Essex CSC since 2006 and health since 2007 of all domestic abuse cases where children are resident.
- 5.20 There was no evidence presented to this review that there were any ethnic, cultural, religious or linguistic issues that affected the services that agencies delivered to this family.

6. Lessons Learnt

- 6.1 This review has highlighted issues of good and poor practice that have been identified previously in other reviews of domestic abuse prior to the inception of DHRs as well as serious case reviews of child and adult protection cases. Rather than turn those items of poor practice into recommendations which are reminders to staff to apply current procedures and act in accordance with good practice, the issues are listed below and agencies should encourage all staff whom may come into contact with families involved in domestic abuse to read this report. Some of these issues are specific to children's services and are outside of the scope of the DHR but they have been included in this list. In addition all agencies in Kent, Medway, Essex and Greenwich should ensure that the findings of this review are incorporated into their existing and any new training in the response to domestic abuse. These matters should also be considered when any policy, guidance or process is being reviewed. The main issues are:

1. The benefit of the creation and maintenance of a chronology which is reviewed at 6 monthly intervals. The chronology should always be considered before the decision to close a case is made or when making significant decisions such as child contact/custody.
2. When families move to an area to make full enquiries with agencies from previous area and to read previous records. This is particularly important when individuals have multiple issues such as mental health

and substance misuse. This will provide a better understanding of the patient/client and previous services supplied rather than rely on them to disclose their history or to rely on their files.

3. To transfer records to the new area in a timely fashion when individuals move.
4. When children are placed out of area children's social care must inform the CSC where they are placed.
5. Before a final decision to return a child in domestic abuse cases CSC must check with the police and other agencies regarding any new incidents or concerns. This is particularly important when children are placed out of area.
6. Referrals to MARAC should be considered using professional judgement for complex cases, such as those involving mental health and substance misuse coupled with abuse that has endured for a long time and violence is escalating.
7. To liaise with other agencies that are providing services to an individual to ensure treatment is complimentary.
8. To consider the family as a whole, especially when a service is treating two or more individuals in a family for mental health issues and substance misuse. In addition there is a need to consider the involvement of victims and offenders as well as having appropriate focus on the needs of the child, the adult and the child/adult relationship.
9. To have current domestic abuse policies.
10. To have an awareness of chronic co-dependent relationships (the 'cannot live together but cannot live apart') relationships.
11. To record details of all information/referrals/services offered and responses from victims and offenders even if it is understood that an agency may already be involved.
12. When there are issues of domestic abuse, mental ill-health and substance misuse which are known as the toxic trio then there is an increased risk of harm to children.
13. All staff who may come into contact with those affected by domestic abuse to have undergone basic domestic abuse awareness training.

14. The importance of sharing information in all domestic abuse and children's safeguarding cases.

7 Recommendations

The review panel has agreed the following actions

7.1 Recommendations for agencies

1. KCA and Greenwich Housing Service to review their policy/method of retention of records to ensure they are able to fully participate in future DHRs and other reviews.

7.2 Recommendation for the Kent and Medway Community Safety Partnerships

1. To review the process for obtaining IMRs and information from agencies and develop an escalation process when an agency from outside Kent and Medway fails to participate in a DHR.

7.3 Recommendations for Government Departments

1. The Ministry of Justice to consider the creation of a good practice guide, including a check list for Probation Trusts for all HDC Assessments to include domestic abuse and child protection.
2. The Home Office to consider issuing guidance to police forces regarding transfer of information between police forces when victims and offenders involved in domestic abuse move.
3. The Home Office to work with the NHS National Commissioning Board and Clinical Commissioning Groups regarding publication of guidance for the commissioning and writing of IMRs from health providers, in particular developing a protocol for obtaining information from other areas.
4. The Home Office, the NHS National Commissioning Board and Clinical Commissioning Groups to develop a training programme for IMR authors from the health economy.
5. Home Office to issue guidance to Independent Chairs and Authors regarding involvement in a DHR of persons convicted of domestic homicide who have been victims of domestic abuse.
6. The Home Office consider developing guidance regarding the identification of a lead professional in cases of domestic abuse where there are other significant issues such as mental ill-health, alcohol or

drug misuse especially when one or more of those issues affects both victim and offender. The process could be similar to the one that already exists in the Care Programme Approach for the mentally ill or in the Child Assessment Framework.

Greg Barry
Independent Chair and Author