OFFICIAL SENSITIVE

KENT & MEDWAY

MULTI-AGENCY REVIEW

Mary/2018

Executive Summary

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Commissioned by:
Kent Community Safety Partnership
Medway Community Safety Partnership
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EXECUTIVE SUMMARY

1. The Review Process

1.1 This summary outlines the process undertaken by the Multi-Agency Review Panel in reviewing the death of Mary Lucas, who lived in Kent.

1.2 Mary was not the victim of a homicide (the killing of one person by another), but paragraph 18 of the Multi-Agency Statutory Guidelines for the Conduct of Domestic Homicide Reviews states:

> *Where a victim took their own life (suicide) and the circumstances give rise to concern, for example that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable.*

1.3 In accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004, the Chair of the Kent Community Safety Partnership decided that this criterion for a Domestic Homicide Review had been met and that a Multi-Agency Review (MAR) would be conducted using the DHR methodology set out in the statutory guidance. The review began on the 11th June 2018.

1.4 To protect their identities of the deceased and her family members, she is referred to in this MAR as Mary Lucas.

1.5 Mary was a white British woman, who was in her 50s at the time of her death in May 2018. At that time, she had been married to William Davis since early January 2018.

1.6 The DHR Core Panel met on 11th June 2018 and agreed that the criteria for an MAR were met. The Chair of the Kent Community Safety Partnership then made the formal decision that an MAR would be conducted. Agencies that potentially had contact with Mary and/or William prior to Mary's death were contacted and asked to confirm whether they had contact with them.

1.7 Those agencies that confirmed contact with the Mary and/or William were asked to secure their files.

2. Contributing Organisations

2.1 Each of the following organisations were subject of an IMR:

- Kent Police
- Centra
- GP Practice 1 (Mary's GP) *
- Kent Community Healthcare Foundation Trust
- Area A Council
- Kent County Council Adult Social Care and Health (Primary Care Mental Health Team)

* To protect the anonymity of Mary and her family, GP practices are not named.

2.2 In addition to the IMRs, a report was requested and received from the National Probation Service.

3. Review Panel Members

3.1 The Review Panel was made up of an Independent Chairman and senior representatives of organisations that had relevant contact with Mary and/or William. It also included a senior member of Kent County Council Community Safety Team.

3.2 The members of the panel were:

• Kate Bushell	North Kent CCG
• Deborah Cartwright	Oasis Domestic Abuse Service
• Catherine Collins	KCC Adult Social Care and Health
• Susie Harper	Kent Police
• Lee Whitehead	Kent Police
• Kay Maynard	Kent Police
• Tina Hughes	National probation Service
• Leigh Joyce	Centra
• Paul Pearce	Independent Chairman
• Shafick Peerbux	KCC Community Safety
• Roxanne Sheppard	Area A Borough Council
• Tim Woodhouse	KCC Public Health

3.3 Panel members hold senior positions in their organisations and have not had contact or involvement with Mary or William. They met on three occasions during the MAR.

4. Independent Chairman and Author

4.1 The Independent Chairman and author of this overview report is a retired senior police officer who has no association with any of the organisations represented

on the panel and who has not worked in Kent. He has experience and knowledge of domestic abuse issues and legislation, and an understanding of the roles and responsibilities of those involved in the multi-organisation approach to dealing with domestic abuse.

4.2 The Independent Chairman has a background in conducting reviews (including Serious Case and Safeguarding Reviews), investigations, inquiries and inspections. He has carried out senior level disciplinary investigations and presented at tribunal. He has completed the Home Office online training on DHRs, including the additional modules on chairing reviews and producing overview reports.

5. Terms of Reference

These terms of reference were agreed by the MAR Panel following their meeting on 24 July 2018.

5.1 Background

In May 2018, Mary Lucas, aged 52 years, was found dead by police officers at her home in Kent. It is believed that she may have taken her own life.

At the time of Mary's death, her husband William was in prison, having been remanded in custody for assaulting her causing grievous bodily harm, coercive or controlling behaviour and perverting the course of justice. It is believed that Mary may have taken her own life.

Mary was not the victim of a homicide (the killing of one person by another), but paragraph 18 of the Multi-Agency Statutory Guidelines for the Conduct of Domestic Homicide Reviews states:

> *Where a victim took their own life (suicide) and the circumstances give rise to concern, for example that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable.*

Consequently, in accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004, a Kent and Medway Domestic Homicide Review (DHR) Core Panel meeting was held on 11 June 2018. It agreed that the criteria for a multi-agency review (MAR) had been met and this review will be conducted using the DHR methodology.

That agreement has been ratified by the Chair of the Kent Community Safety

Partnership and the Home Office has been informed.

5.2 The Purpose of the MAR

The purpose of the MAR is to:

a) establish what lessons are to be learned from the death regarding the way in which local professionals and organisations work individually and together to safeguard victims;
b) 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;
c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
d) prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
e) contribute to a better understanding of the nature of domestic violence and abuse; and
f) highlight good practice.

5.3 The Focus of the MAR

This review will establish whether any agencies have identified possible and/or actual domestic abuse that may have been relevant to the death of Mary Lucas.

If such abuse took place and was not identified, the review will consider why not, and how such abuse can be identified in future cases.

If domestic abuse was identified, this MAR will focus on whether each agency's response to it was in accordance with its own and multi-agency policies, protocols and procedures in existence at the time. If domestic abuse was identified, the review will examine the method used to identify risk and the action plan put in place to reduce that risk. This review will also consider current legislation and good practice. The review will examine how the pattern of domestic abuse was recorded and what information was shared with other agencies.

The subject of this review will be the deceased, Mary Lucas.

5.4 MAR Methodology

The MAR will be based on information gathered from IMRs, chronologies and reports submitted by, and interviews with, agencies identified as having had contact with Mary and/or William in circumstances relevant to domestic abuse, or to factors that could have contributed towards domestic abuse, e.g. alcohol or substance misuse. The

MAR Panel will decide the most appropriate method for gathering information from each agency.

Independent Management Reports (IMRs) and chronologies must be submitted using the templates current at the time of completion. Reports will be submitted as free text documents. Interview will be conducted by the Independent Chairman.

IMRs and reports will be prepared by an appropriately skilled person who has not any direct involvement with Mary or William, and who is not an immediate line manager of any staff whose actions are, or may be, subject to review within the IMR.

Each IMR will include a chronology and analysis of the service provided by the agency submitting it. The IMR will highlight both good and poor practice, and will make recommendations for the individual agency and, where relevant, for multi-agency working. The IMR will include issues such as the resourcing/workload/ supervision/support and training/experience of the professionals involved.

Each agency required to complete an IMR must include all information held about Mary or William from 1 January 2016 to early May 2018. If any information relating to Mary being a victim, or William being a perpetrator, of domestic abuse before 1 January 2016 comes to light, that should also be included in the IMR.

Information held by a statutory agency that has been required to complete an IMR, which is relevant to the homicide, must be included in full. This might include for example: previous incidents of violence (as a victim or perpetrator), alcohol/substance misuse, or mental health issues relating to Mary and/or William. If the information is not relevant to the circumstances or nature of the homicide, a brief précis of it will be sufficient (e.g. In 2015, X was cautioned for an offence of shoplifting).

Any issues relevant to equality, for example disability, sexual orientation, cultural and/or faith should also be considered by the authors of IMRs. If none are relevant, a statement to the effect that these have been considered must be included.

When each agency that has been required to submit an IMR does so in accordance with the agreed timescale, the IMRs will be considered at a meeting of the MAR Panel and an overview report will then be drafted by the Independent Chairman. The draft overview report will be considered at a further meeting of the MAR Panel and a final, agreed version will be submitted to the Chair of Kent CSP.

5.5 Specific Issues to be Addressed

Specific issues that must be considered, and if relevant, addressed by each agency in their IMR are:

i. Were practitioners sensitive to the needs of the Mary, knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

ii. Did the agency have policies and procedures for Domestic Abuse, Stalking and Harassment (DASH) risk assessment and risk management for domestic violence and abuse victims or perpetrators and were those assessments correctly used in the case of Mary? Did the agency have policies and procedures in place for dealing with concerns about domestic violence and abuse? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC or other multi-agency forums?

iii. Did the agency comply with domestic violence and abuse protocols agreed with other agencies, including any information-sharing protocols?

iv. What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

v. Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?

vi. When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?

vii. Was anything known about the perpetrator? For example, were they being managed under MAPPA? Were there any injunctions or protection orders that were, or previously had been, in place?

viii. Had the victim disclosed to any practitioners or professionals and, if so, was the response appropriate?

ix. Was this information recorded and shared, where appropriate?

x. Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?

xi. Were senior managers or other agencies and professionals involved at the appropriate points?

xii. Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?

xiii. Are there ways of working effectively that could be passed on to other organisations or individuals?

xiv. Are there lessons to be learned from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

xv. Did any staff make use of available training?

xvi. Did any restructuring during the period under review likely to have had an impact on the quality of the service delivered?

xvii. How accessible were the services to the Mary?

6. Summary Chronology

6.1 William Davis contacted Mary Lucas via Facebook, following his release from prison on licence in November 2016. They had known each other at school but had no contact for over 30 years.

6.2 Mary suffered from a physical disability caused when she had been taken hostage while working as a prison officer over ten years prior to her death. Her vulnerability increased when she separated from her husband shortly after Christmas 2016, leaving her living alone.

6.3 William persuaded Mary to let him live with her. He was on licence and needed an address that was suitable for the National Probation Service to direct him to reside at. Having spoken to Mary as part of this process, William's Probation Officer directed him to live at her home. Although it seemed at the time that she was happy with this, it subsequently emerged that she had not wanted him to move in. This indicates that William was subjecting her to coercion and control from soon after they re-met.

6.4 Mary divorced during 2017 and in early January 2018, she and William married. She later disclosed that he forced her to marry him against her will.

6.5 Mary first reported domestic abuse by William at the end of January 2018. He was arrested for this and bailed. He left her home and went to live outside Kent. He failed to surrender to bail and opportunities were missed to arrest him and recall him to prison. In early March, Mary withdrew her statement of complaint against William and he began living with her again. This happened because Mary was being subjected to coercion and control by William; she was frightened and vulnerable. Organisations did not appreciate that the decisions she was making were due to this.

6.6 In the first week of May 2018, Mary again reported abuse by William, including a serious physical assault. He was arrested, charged and kept in custody to appear before magistrates. He was granted bail, but the Crown Prosecution Service appealed this decision and William was kept in custody pending the result of the appeal.

6.7 Mary was told in error that William had been released on the afternoon of the Friday before a bank holiday weekend. She believed that this put her life at risk. She died of a prescription drug overdose sometime during that weekend. William had been recalled to prison on licence on the Friday.

6.8 The simple facts belie the extent of the abuse Mary had been suffering for months before she first reported it, and during the period after William returned to her home. She suffered greatly and was a frightened and vulnerable woman. The review has considered the way in which organisations were involved with Mary and has produced conclusions, lessons identified and recommendations.

7. Conclusions

7.1 In late 2016, William contacted Mary using Facebook, having previously known her when they were at school together. Why he chose to contact her is unclear, but at the time she was physically and emotionally vulnerable. She suffered from a physical disability for which she needed support and was living alone for the first time in over 30 years, having recently separated from her husband. In addition, her father had earlier died in 2016. Within a few months of contacting Mary, William was living in her home.

7.2 Mary first reported domestic abuse by William at the end of January 2018, by which time they were married. She said the abuse had been going on for some months. Although he moved out following his arrest a week later, he coerced her into withdrawing her allegations and moved back into her home. He was subjecting her to physical, psychological and emotional abuse, which escalated to a point where he was again arrested and charged with serious assault. He remained in custody and his prison release licence was revoked. Mary was told on a Friday afternoon that he had been released and she died during that

weekend.

7.3 It is significant that when she was told William had been released on bail, Mary said '…*it was as though the magistrates had signed her death warrant'*. What she meant by this was not explored, but it is possibility that she was intimating an intention to take her own life. A professional who had received suicide prevention training may have asked Mary to clarify the statement with a view to identifying if she was at risk of suicide.

7.4 The risk of a victim of domestic abuse taking their own life has been recognised; it is why reviews using DHR methodology, such as this one, are conducted. Some recent research into the risk is contained in a study carried out jointly by Refuge and Warwick Law School:

https://www.refuge.org.uk/wp-content/uploads/2018/07/domestic-abuse-suicide-refuge-warwick-july2018.pdf

Some statistics about the increased risk were included in a prestation given at an Advocacy After Fatal Domestic Abuse conference about Suicide and Domestic Abuse, held on 21st March 2019:

https://aafda.org.uk/2019presentations/eleanor-stobart-dhrs-and-suicide-aafda-conference-21-march-2019/

Free to access suicide prevention training is available in Kent and Medway. Adult suicide prevention training for KCC staff can be accessed at:

http://www.maidstonemind.org/suicide-prevention-awareness-training/

A 20-minute e-learning package is available at:

https://www.zerosuicidealliance.com/

7.5 Kent County Council to consider using their commissioning relationship with the domestic abuse service providers to require that all front facing staff (IDVAs, outreach workers etc) complete face to face suicide prevention training.

7.6 All agencies involved in this review should add suicide prevention training to their directory of training available to staff and encourage take up.

7.7 Several examples of good practice, based on individual performance and organisational practices, have been highlighted in this review. Information was shared between organisations to an extent not seen in many earlier reviews, indicating its values is better understood.

7.8 Organisations knew for three months before Mary's death that she was a victim of domestic abuse, although the abuse had been taking place for months before any became aware of it. She was identified as a high-risk victim, but a chain of events

began that raises concerns about how organisations responded. In some cases, this was individual error, in some a more worrying indication of cultural shortcomings. The review panel understands that professionals are human and make mistakes; this review does not seek to apportion blame to them, but to learn lessons for the future. It is important however, to identify clearly each issue of concern.

7.9 The MARAC referral from Kent Police was made promptly but was not sent to the correct destination. This delayed by two months Mary's case being heard. It was just over three months from the date when organisations first knew Mary was a domestic abuse victim to her death, which shows how important it is that processes which seek to safeguard high-risk victims are implemented expeditiously, with a degree or urgency.

7.10 A lack of available police officers meant William was not arrested when he tried to surrender to bail; this was significant. During the period between then and his eventual arrest, he told Mary he had information about her family that he would disclose if she did not retract her allegations and allow him back to live in her home. She did both, which resulted in further abuse, compounded by a failure by organisations to consider why she might have done this.

7.11 The decision not to recall William to prison after his first arrest was based on professional judgement, but it is harder to see why this decision was not at least reviewed when he failed to surrender to police bail. To have deprived him of his liberty at that point would have changed the course of Mary's suffering.

7.12 The Review Panel accepts that there is greater certainty in hindsight about why Mary made the decisions she did. However, there is concern that there was a lack of consideration and understanding about why a high-risk domestic abuse victim might withdraw allegations, and apparently reconcile with an alleged abuser. It should have been recognised that these decisions were indicative of Mary suffering increased coercion and control, putting her at higher risk. In common with separation, resumption of cohabiting and withdrawal of complaint, are factors that should cause professionals to become concerned and curious.

7.13 There is little evidence that Mary's vulnerability due to her physical disability formed part of professionals' considerations. As well as the practical consideration that it made her less able to resist physical abuse, her reliance on care in her home day to day might have made her reluctant to report abuse at an early stage.

7.14 When Mary failed to engage with SATEDA, this did not raise any recorded concerns that it might have been because she was being subjected to coercion and control. There were no recorded attempts to establish why she could not be

contacted or why she did not respond to calls.

7.15 The rationale recorded by KCC ASCH when closing the KASAF showed a lack of understanding that a consequence and sign of coercion and control is for domestic abuse victims to make decisions that are contrary to their best interests. It concluded with reasoning that bordered on victim blaming - Mary had withdrawn her allegations and allowed William back into her home.

7.16 On the day William was appearing in court, Mary expressed to her IDVA, her fear that he might be released on bail. The IDVA told her to ring the police custody suite to find out the court result. This demonstrated a lack of empathy and understanding; it was something that should have been done for her.

7.17 There can be little doubt that Mary's death was influenced by her belief that William had been released on bail. The information she was given was wrong because Witness Care staff did not know that an appeal against bail granted by magistrates must result in the defendant being remanded in custody.

7.18 Each of these issues had consequences, and recommendations have been made to try to ensure that in future, the culture and practices of organisations prevent a repetition. Mary was identified as being vulnerable and assessed as being at high risk. There is value in assessing risk only when the appropriate action is taken. High risk victims must be given high priority to ensure their safeguarding as far as possible.

8. Lessons Identified

8.1 Professionals dealing with victims of domestic abuse must look at issues through the eyes of the victim.

8.1.1 This is necessary to ensure that responses are appropriate to individuals and not simply the result of adherence to policy. An appreciation of the level of fear and vulnerability relies on understanding the circumstance of the individual.

8.1.2 Consideration of all aspect of equality and diversity are essential, which may require professionals to consult with others who have experience and understanding of issues.

8.2 If a domestic abuse victim withdraws allegations and/or accepts an alleged perpetrator back into their home, professionals must be aware that this could be because the victim is being subjected to coercion and control.

8.2.1 The circumstances described are one of the potential indicators, along with separation, that a domestic abuse victim may be at increased risk. It must not be assumed that the victim has willingly reconciled with the alleged perpetrator. Professionals should not, as a matter of course, use these circumstances as the reason for closing a domestic abuse case.

8.2.2 If more than one organisation has been involved in supporting the victim, each organisation should discuss the case with the other(s) to ensure that all information about the victim and alleged perpetrator has been shared. In appropriate cases, a professionals meeting may be the most effective way of doing this.

8.2.3 Overall, professionals must understand the impact that coercion and control have on a victim, who may not be able to make decisions in their own best interests.

8.3 Where possible, face to face contact should be sought by professionals dealing with high risk domestic abuse victims.

8.3.1 Care must always be taken when contacting domestic abuse victims to ensure that the means of contact does not place them at greater risk. No attempt should be made to pressure a victim into doing something they feel frightened or uncomfortable about, or which might place them at greater risk of harm.

8.3.2 Notwithstanding those overriding considerations, a face to face meeting, rather than telephone contact, with a high-risk victim will give a trained professional the best opportunity to exercise professional judgement about the risk to which that person is subject. At the very least, their general appearance (including visible injuries) and body language can only be seen by meeting them. It is also harder for the victim to conceal their true feelings and emotions, which will better inform the professionals of their risk and vulnerability.

8.3.3 If a victim declines the opportunity to meet, it is may be an indicator of the degree of coercion and control they are subjected to, or the fear they are living under. Professionals must be mindful of not adding to these but should always consider a meeting as the best way to facilitate accurate professional judgement.

9. Recommendations

9.1 The Review Panel makes the following recommendations from this MAR:

	Recommendation	Organisation
1.	Kent Police must ensure that all VIT officers and staff know where MARAC referrals must be sent.	Kent Police
2.	Kent Police must ensure that its Witness Care staff know that when the Crown Prosecution Service appeal a decision made by magistrates to grant bail, the defendant will be remanded in custody pending the outcome of the appeal.	Kent Police
3.	Kent Police's Witness Care policy and procedures must state clearly that if Witness Care staff have any doubt about the outcome of a court case, they must contact the court for clarification at the earliest opportunity and advise victims and/or witnesses of the uncertainty until it is resolved.	Kent Police
4.	Centra should consider adopting the Kent Police policy that results in a domestic abuse victim who has been assessed at being at High risk, remaining High risk for at least 12 months, regardless of whether one or more subsequent risk assessments results in a lower grade.	Centra
5.	Centra must instruct their IDVAs to record the rationale for their decision whether to meet a victim face to face.	Centra
6.	Kent County Council must, as part of the performance monitoring of its contract with Centra, consider how the concerns identified in this report are being addressed by Centra to ensure that the service provided to high risk victims of domestic abuse is improved.	Kent County Council
7.	AAC should ensure that Revenue & Benefits Team staff seek all the relevant safeguarding information known within AAC about a client they are interviewing.	Area A Council

8.	AAC should consider and decide whether, in the light of this case, Revenue & Benefits Team staff should attend the face to face domestic abuse training module.	Area A Council
9.	KCC ASCH must ensure that when completion of a KASAF 2 is delayed due to exceptional circumstances, the fact that it is outstanding cannot be overlooked.	KCC ASCH
10.	KCC ASCH must ensure that staff dealing with the safeguarding of high-risk domestic abuse victims understand and act on the fact that apparent reconciliation between a victim and alleged perpetrator may be because of coercion and control, and indicative of the victim being at increased risk.	KCC ASCH
11.	Kent and Medway Domestic Abuse and Sexual Violence Group must agree a process that ensures all MARAC meetings are accurately minuted and that the allocation and implementation of actions are recorded. The agreed process should be included in the Kent and Medway MARAC Operating Protocol and Guidelines.	KM DASVG
12.	Kent County Council to consider using their commissioning relationship with the domestic abuse service providers to require that all front facing staff (IDVAs, outreach workers etc) complete face to face suicide prevention training.	Kent County Council
13.	All agencies involved in this review should add suicide prevention training to their directory of training available to staff and encourage take up.	Agencies subject of this review
14.	The Home Office must produce leaflets for family members and friends that are suitable for reviews using the DHR methodology in cases where a person has taken their own life.	The Home Office