

Domestic Homicide Review

Ann/November 2018

Executive Summary

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Commissioned by:
Kent Community Safety Partnership
Medway Community Safety Partnership

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1. The Review Process

- 1.1 This summary outlines the process undertaken by the Kent and Medway Domestic Homicide Review Panel in reviewing the death of Ann who was a resident in their area.
- 1.2 The following pseudonyms have been used in this review for the victim, offender and other family members to protect their identities.

Name	Relationship to Ann (Deceased)	Relationship to George (Offender)
Claire	Daughter	Estranged wife
Rose	Granddaughter	Daughter
Dan	Grandson	Stepson
Robert	Friend	Cousin

- 1.3 Ann was a white British female in her sixties. George is a white British male in his fifties. Claire is a white British female in her forties. Rose is a white British female under sixteen. Dan is a white British male in his twenties. Robert is a white British male in his fifties.
- 1.4 Following a three week trial at Crown Court, George was convicted of murder and attempted murder. He was sentenced to 32 years imprisonment.
- 1.5 The Domestic Homicide Review Core Panel met at the end of 2018 and agreed the criteria to conduct a review had been met. All agencies that potentially had contact or involvement with Ann, George and their immediate family (as detailed at paragraph 1.2) were contacted and requested to secure their files.

2. Contributing Organisations

- 2.1 The following organisations provided Individual Management Reports (IMR) detailing any involvement they had with any members of the family prior to the death of Ann.
- Kent Police
 - A Kent Clinical Commissioning Group (CCG) covering the GP surgery
 - A Kent Acute NHS Trust
 - Kent & Medway NHS Social Care Partnership Trust
 - Kent County Council (KCC) Children's Social Work Services
 - Kent, Surrey and Sussex Community Rehabilitation Company (CRC)

- Kent Education Safeguarding Service
- 2.2 In addition to the Independent Management Reports, the Kent Fire and Rescue Service, Ambulance Service and Victim Support were requested to submit brief reports on their involvement with the family following the death of Ann. The Review Panel concluded none of these organisations needed to participate in the review process.
- 2.3 The authors of the IMR responses were all senior members of the organisations involved and had no previous contact or involvement with Ann, George or the immediate family.

3. Review Panel Members

- 3.1 The Review Panel consisted of an Independent Chair and senior members of the organisations who had identified previous contact with Ann, George or other members of the family.
- 3.2 All panel members made a declaration of independence and a commitment to review the conduct of their organisations to identify good practice and areas for improvement.
- 3.3 The panel members were:

Claire Axon-Peters	NHS Clinical Commissioning Group
Afifa Ali	KCC Children's Social Work Service
Samantha Mercer	Kent Police
Debbie Tolhurst	Kent and Medway NHS Social Care Partnership Trust (KMPT) (Mental Health)
Tamsin Fletcher	Kent, Surrey and Sussex Community Rehabilitation Company (KSS CRC)
Peter Lewer	Kent Education Safeguarding Service
Sarah Nichols	Kent Safeguarding Children Board
Catherine Collins	Kent Adult Social Care and Health
Kathleen Dardry	KCC Community Safety
Deborah Cartwright	Oasis - Domestic Abuse Service (Document review only)
David Pryde	Independent Chair

- 3.4 The panel met on three occasions during the process. The Terms of Reference meeting was on 27th February 2019. The first IMR meeting was held on 20th June 2019 to review the initial responses from each organisation. The panel met again on 9th September 2019 to consider the draft Overview Report. The Chair engaged with an AAFDA subject matter expert (Advocacy After Fatal Domestic Abuse) to quality assure the draft report and help the family with the process.

4. The Independent Chair and Author

- 4.1 The Independent Chair and author of this overview report is a retired Hampshire Police Chief Officer, who has no association with any of the organisations represented on the panel. He did serve with Kent Police, leaving the organisation in 2007 on promotion. He has experience and knowledge of domestic abuse issues and legislation, and a thorough understanding of the roles and responsibilities of those involved in a multi-agency approach dealing with domestic abuse.
- 4.2 The Independent Chair has considerable experience conducting reviews, investigations and inspections. He has completed the Home Office online training on DHRs and the additional modules on chairing reviews and producing overview reports.
- 4.3 The Independent Chair is currently the Safeguarding Advisor to the Bishop of Winchester and carries out the role of Independent Chair for the Winchester Diocese Safeguarding Board. To support this role, he is an associate member of the Social Care Institute of Excellence.

5 Terms of Reference

- 5.1 The Review Panel first met on 27th February 2019 to consider draft Terms of Reference, the scope of the DHR and those organisations whose involvement would be examined. The Terms of Reference were agreed subsequently by correspondence and form Appendix A of the Overview Report.
- 5.2 This report has been anonymised and the personal names contained within it are pseudonyms. This does not include the DHR Panel members.
- 5.3 The pseudonyms were chosen by the members of the family with particular care taken over the name chosen for the deceased. The perpetrator was not consulted.

6 Summary Chronology

- 6.1 This DHR was commissioned following a fatal fire that occurred in November 2018.

- 6.2 On this day the police attended a dwelling house in Kent and found the house ablaze and a young child (Rose) lying on the ground suffering from smoke inhalation and injuries to her leg. They were informed Rose had jumped from the upstairs window to escape the flames and that her grandmother (Ann) was still inside.
- 6.3 On arrival of the Fire Service, Ann was rescued and both were taken to hospital. Ann did not recover from her injuries and life was pronounced extinct a short time later. The cause of death was asphyxiation.
- 6.4 George was quickly identified as a suspect and arrested.
- 6.5 The family were broadly unknown to the statutory agencies and what is a feature of this Review is how quickly matters deteriorated over a very short period of time.
- 6.6 To illustrate this, exact dates have been included in this commentary and the family consulted as to the potential impact this could have on their anonymity. They have all given their express permission for this approach to be taken.
- 6.7 During February 2018 both Claire and George attended their local GP separately to seek help for depression. George did not keep any further appointments. Claire made two further visits before discontinuing her treatment.
- 6.8 During the early hours of 18th October 2018 Claire contacted the police reporting her husband George had assaulted her and taken her car. The police attended and took a further report that her husband had also assaulted her two days ago. A DASH risk assessment was completed and graded as a medium risk. A DASH (**D**omestic **A**buse, **S**talking and **H**onor based violence) is a questionnaire containing 27 questions that help identify 'high risk' cases of domestic abuse where there is strong probability of serious harm. Assessments graded high are automatically sent to a Multi Agency Risk Assessment Conference (MARAC).
- 6.9 George was arrested and charged with two counts of common assault and taking a vehicle without consent. He had strict bail conditions not to contact Claire or attend the marital home.
- 6.10 Within minutes of his release on the 19th October 2018 he sent a Facebook message to Claire stating, "What the f**k?". An hour later George was outside the house. Another DASH assessment was completed and graded as medium.
- 6.11 George was arrested and appeared in court the next day. Police opposed bail on the grounds the current bail address was literally around the corner from the former marital home and therefore completely unsuitable. George was released on the same conditions.
- 6.12 Around 6am on 25th October 2019 Claire found a ladder propped up against an open upstairs window and then saw George standing on the back patio. Police

attended and completed another DASH assessment, graded as medium. George was not located at that time and his arrest was not actively pursued.

- 6.13 Children's Social Services contacted Claire the same day to enquire about the incident on the 19th October. This contact was prompted by a DAN. A DAN (Domestic Abuse Notification) is created by the police and sent to Social Services every time they attend a domestic abuse incident and there is a child or vulnerable person in the household who may be at risk. It forms part of the DASH risk assessment process. After speaking to Claire, Children Social Services provided contact details of support services available to her and filed the case as closed.
- 6.14 On 28th October 2018 Claire contacted the police complaining about text messages to her and Rose. The DASH assessment failed to identify Rose as a victim and remained graded as a medium risk. This conduct was in express violation of his bail conditions. George was arrested the following day and taken to court. He was released with no changes to his bail conditions.
- 6.15 On the 30th October 2018 Claire contacted the police complaining George was sending Rose 100s of text messages a day. Rose was distressed and overwhelmed by the content and volume. The following day she reported to the police her daughter had seen George in the back garden and later on the same day Rose had received another 100 plus texts making various threats.
- 6.16 Claire contacted the police on the 1st of November 2018 reporting a note she had found she believed to have come from George. On the 2nd November 2018 she reported George was at her house trying to break in. Police attended, completed a DASH and S/DASH assessment, both graded as medium. (S/DASH is an additional 12 questions asked when there is clear evidence of stalking behaviour). This was despite the DASH assessment detailed a number of 'high risk' DASH factors and provided evidence of stalking behaviour. The S-DASH assessment did not accurately reflect the circumstances as reported. The police subsequently located George, arrested him and took him straight to court.
- 6.17 Bail was opposed by both the police and the Crown Prosecution Service (CPS), but George was released, with no changes made to his bail conditions. Gaps in the information supplied to the Magistrates to refuse bail did not make this a perverse decision.
- 6.18 On the 4th November 2018 the police were advised George had travelled to a location on the South Coast where Claire and Rose were resident visiting Robert. George had been texting Claire, stating he knew exactly where she was. Robert contacted Kent Police who completed another DASH assessment, again graded as medium. No further action was taken.
- 6.19 George entered a guilty plea to two charges of common assault against Claire on the 5th November 2018. His sanctions included a Protection from Harassment Restraining Order. This Order had the same conditions as his

previous bail conditions, which he had breached on multiple occasions in the previous two weeks and maintained the unsuitable bail address as his curfew address. The sentencing Magistrates did not get a comprehensive pre-sentencing report to enable them to make a more informed judgement.

- 6.20 On 13th November 2018 George was admitted to his local hospital following an alcohol/drug overdose. He was assessed by the mental health team who determined he did not pose a threat to himself or anyone else. This was an assessment made solely on their interaction with George without any referral to any other agency.
- 6.21 On 14th November 2018 George kept an appointment with his probation officer. The focus of this visit was his wellbeing following his release from hospital, as against any risk he posed to Claire or Rose. Incomplete paperwork and a lack of contact with any other agency to ascertain what information they had in relation to George were major contributing factors to this approach.
- 6.22 Later the same day, George attended the former marital home and made aggressive demands to hand over a television. This was in complete breach of the Harassment Order. The police did not attend but completed another DASH assessment and graded it as medium.
- 6.23 In late November 2018, the day of the fire, Claire was visiting Robert on the South Coast and Rose was at home being looked after by Ann. The police were advised that George was texting Claire and he had contacted Rose stating he was outside the house and he knew where Claire was. He told Rose he intended to set fire to the mobile home Claire was in. Serious concerns were expressed to the police about the risk George posed.
- 6.24 The police response was to complete another DASH assessment, again, graded as medium and provide safety advice on the telephone to Ann. They did not dispatch a police patrol to the address in Kent.
- 6.25 Some three hours later after the initial telephone call, Rose contacted the police stating George was outside the house, banging on the windows trying to gain entry. Whilst on the phone to the police operator, she further advised the house was on fire, her grandmother (Ann) and family dog were slumped on the floor and she was going jump from the bedroom window to escape the smoke and flames.

7. Conclusions

- 7.1 In addition to the procedural errors made by a number of the organisations involved, there is one overarching theme - there was limited effective inter-agency working.
- 7.2 Where information sharing did take place, it was either incomplete or inaccurate in terms of highlighting the potential risk George posed to Claire, Rose, Dan and Robert.

- 7.3 The DASH process and its practical application appears to be at best problematic, at worst a contributing factor to the events that led up to and included the fatal fire in November 2018.
- 7.4 How repeated DASH and S-DASH assessments remained at medium is difficult to justify. There is no doubt a medium grading would have influenced the thinking of decision makers in the Criminal Justice System and the decisions they subsequently then made.
- 7.5 Just one DASH or S-DASH assessment graded as 'High' would have triggered inter-agency engagement through the tried and tested MARAC process.
- 7.6 The checks and professional judgement that should have been applied when each DASH assessment was reviewed independently by police supervisors in the CRU were not effective. In a number of cases the information detailed on the DASH did not correlate with the information on either the crime report or incident report. Thus, while the information was available to the police, it was not acted upon. This meant DAN alerts were not sent to Social Services as they should have been and the opportunity to make a referral to the MARAC missed.
- 7.7 The police response to a number of the complaints made by Claire about George's conduct should have been more consistent and robust. By not expediting the arrest of George as soon as possible after each breach of bail, his behaviour was allowed to go unchecked.
- 7.8 Not dealing with Rose as a victim in her own right, the stalking of her by George, sending 100s of text messages to her on a daily basis, was a major omission. It was a real missed opportunity not to assess the content and nature of these texts and come to a conclusion the risk to Claire channeled through Rose was escalating. It also meant Rose continued to be a victim and her levels of distress and anxiety were not dealt with. The threats to cause Claire serious harm or injury were made to Rose, not Claire which is also significant given George could have made these threats direct. He did after all pay little heed to his bail conditions/Restraining Order. As highlighted in a recent Kent DHR (Rosemary 2017), there is research that suggests there are direct links to stalking and domestic homicide. This research was conducted by Jane Monckton-Smith, Karolina Szymanska and Sue Haile for the Suzy Lamplugh Trust¹.
- 7.9 A number of organisations took at face value what George told them as factually correct. They didn't make any checks to corroborate with other partners that what he had said was true. This meant the risk he posed was not managed.
- 7.10 There were more than enough indicators that, despite Rose being his daughter, he was prepared to abuse her as a means of getting to her mum. George was in regular contact by text and on more than one occasion attended the home address when Rose was either present or indeed alone in the house. His

¹MoncktonSmith, J, Szymanska, K. and Haile, S (2017) Exploring the Relationship between Stalking and Homicide. Suzy Lamplugh Trust.

conduct and comments both by text and verbally were becoming more erratic and threatening as time progressed. As previously stated the risks to Rose were lost by the focus on managing the risk to her Mum and the involvement of Rose was effectively pushed to one side. George knew when he set fire to the house only Rose and Ann were inside. He believed Claire was not in Kent. This unequivocally demonstrates he had a total disregard for the safety of Rose. While Claire was the main focus of his attention in terms of retribution for the break-up of the marriage, Rose and Ann became collateral damage in seeking his revenge. Here, there are parallels with the previous Kent and Medway DHR; Sarah 2013, where the daughter in the family was not adequately recognised during risk assessments or through DANs, despite her taking on the responsibility to contact the Police on a number of occasions.

- 7.11 Had either the Psychiatry Liaison Team or the CRC been in touch with the police, their understanding George was a loving father with minimal contact with Rose would have been quickly dispelled. They would have also discovered George had regularly breached his conditional bail and his Restraining Order, which are not the actions of a compliant or truthful individual.

8. Lessons to be learnt

- 8.1 The DASH assessment process in this case did not meet the needs of victims nor provide them with adequate protection. At no time did anyone display sufficient professional curiosity to explore why so many DASH and S-DASH assessments were completed over such a short period of time and as a consequence reassess and apply professional judgement to the cumulative risk posed. DAN alerts that should have been passed to Social Services were not sent.
- 8.2 The management of the DASH assessment process and the information that is shared with partners needs to be reviewed.
- 8.3 Relying solely on one person's account as to the circumstances they find themselves in as the basis of a risk assessment on what threat that person may pose to themselves or others is inherently dangerous.
- 8.4 Seeking information from other partners to provide contextual information to test the veracity of the information they are being given is good practice.
- 8.5 The voice of the child was not only not heard; it was completely overlooked.
- 8.6 Issues regarding 'the voice of the child' from the Kent and Medway DHR 'Sarah 2013' around the impact of domestic abuse on a child, responding to a child exposed to domestic abuse and the information that a child can contribute in such situations, have repeated.
- 8.7 The warning signs and escalation of the stalking behaviour displayed by George were not recognised as a precursor to more extreme conduct.

- 8.8 Providing protection to victims through conditional bail and/or Restraining Orders will only be effective if these conditions are vigorously enforced and when breached, an early arrest made.
- 8.9 Information provided to partner agencies needs to be accurate, comprehensive, timely and given in a spirit of co-operation and collaboration. The needs of the victim should be paramount and the effective management of alleged perpetrators should take precedence over the supposed constraints introduced by GDPR. There is sufficient scope within these Regulations for organisations to be significantly less risk averse than they currently are when it comes to sharing information with statutory partners.

9 Recommendations

- 9.1 The Panel makes the following recommendations from this DHR:

	Recommendation	Organisation
1	The GP Surgery should establish a protocol for reviewing patients who have presented at A&E following a suicide attempt. This will include dealing with scanned correspondence in a timely manner and agreeing with Kent Police a process to notify them should a Firearms licence holder and/or applicant make a suicide attempt.	CCG and Kent Police
2	How DASH is used and how to manage increased risk needs to be reviewed, particularly at an operational level. Due regard to the importance of professional curiosity and judgement should be emphasised. The plan to participate in a pilot sponsored by the College of Policing for a new domestic abuse risk assessment scheduled to start before the end of 2019 will provide additional training and awareness, especially around coercion and control, to the workforce.	Kent Police and The College of Policing
3	Specific action should be taken to address the lack of understanding in responding to Section 10 of the current DASH assessment and the importance of listening and more importantly responding effectively to 'the voice of the child'.	Kent Police
4	A strategic review should be undertaken in respect of the role and responsibilities undertaken by the Information Management Unit, Force Control Room and Central Referral Unit in domestic abuse incidents.	Kent Police

	Recommendation	Organisation
	This should take due regard to the recommendations made by HMICFRS following their recent inspection and their view that a MASH function should be established.	
5	The use of the risk management tool RARA as a process to manage risk needs to be reinforced with operational officers. This will require a training review and a communication plan.	Kent Police
6	The Stalking SPOC initiative launched in July 2019 should be regularly reviewed to ensure best practice and lessons learned are identified at the earliest opportunity and disseminated to practitioners to enable them to deliver the best possible service to victims.	Kent Police
7	Current policy regarding the management of a breach of bail conditions/harassment orders should be reviewed. Specific measures should be introduced that ensure any breaches are actioned in a timely manner.	Kent Police
8	The measures introduced following the Ofsted inspection in January 2019 of Front Door should be revisited to ensure there is compliance with a sharper focus on risk and urgency. An accompanying training needs analysis should be undertaken with Front Door staff. This may identify further areas of training that should be undertaken to ensure the staff are both knowledgeable and confident when dealing with the complexities that are inherent with domestic abuse incidents.	Kent Children's Social Services
9	There needs to be more effective information sharing and challenge of partner agencies. The establishment of a MASH type functionality and structure should close this gap. Social Services will need to prioritise finite resources to support this initiative if they are to extract the clear benefits that such an information sharing platform provides.	Kent Social Services and Kent Police
10	The measures put in place following the Serious Further Offences Review in April 2019 should be revisited to ensure these are being robustly applied. These measures should also be shared with the Ministry of Justice managing the transition of Community Rehabilitation Companies as they transition back into the National Probation Service.	KSS Community Rehabilitation Company

	Recommendation	Organisation
	(Home Office Quality Assurance Panel Recommendation).	
11	There needs to be more effective information sharing and challenge of partner agencies. The establishment of a MASH type functionality should close this gap. The CRC will need to prioritise finite resources to support this initiative if they are to extract the clear benefits such an information sharing structure has to offer.	KSS Community Rehabilitation Company and Kent Police
12	A training needs analysis should be carried out to identify current gaps in training and awareness. It has already been noted that current training focuses on victims of domestic abuse rather than perpetrators. Additional specialist training facilitated by external subject matter experts will help to reinforce the need to challenge and check with other agencies any account given by a patient who is wearing a tag or admits to previous criminality involving domestic abuse. Mandatory referral to the Police Liaison Officer in these circumstances is good practice.	KMPT and Domestic Violence Service
13	Additional safeguarding training should be considered best practice for schools who operate separate pastoral support systems.	Education Safeguarding Service
14	Operation Encompass should be expanded to include Secondary Schools in advance of the pending Domestic Abuse Bill.	Education Safeguarding Service and Kent Police
15	The Home Office should explore with the Department of Local Government, Housing and Communities the feasibility of establishing a permanent hardship fund for domestic abuse victims that mirrors the current arrangements for former residents of Grenfell Tower.	The Home Office