Domestic Homicide Review

Summary of recommendations

Under s9 of the Domestic Violence, Crime and Victims Act 2004

Review into the death of Catherine
in September 2017

'Catherine' was 42-year-old woman who took her own life in September 2018.

She had married in 2006 but at the time of her death was separated from her husband and living in the flat they had shared together. They had one child who was in the legal care of his paternal grandmother. She had three older children from previous relationships.

A police investigation was undertaken into the circumstances of Catherine's death which concluded that no-one else had been involved and no criminal charges were brought. At Inquest, HM Coroner concluded that she was suffering from a 'toxic trio' of issues – alcohol abuse, mental ill-health and domestic abuse. The high standard of proof needed to consider suicide as a finding was reached and thus it was determined that Catherine intended to take her own life.

A subsequent Domestic Homicide Review came to the following conclusions:

- The review supported entirely the comments made by HM Coroner that Catherine was subject to a 'toxic trio' of issues, mental ill-health, alcohol abuse and domestic abuse. It is clear that all three contributed to her suicide. In addition, it has become clear when undertaking the review that the arrangements for the care of Catherine's youngest child weighed heavily upon her as she felt it prevented her from finally leaving the relationship with her husband.

- The chronology of events highlighted the level of interaction that Catherine and her husband had with a variety of agencies. Catherine engaged, and disengaged at various times, with different agencies.

- The review highlighted a number of missed opportunities in agencies interaction with Catherine. However, none of these, taken in isolation, would have made a significant difference to Catherine and the outcome for her but, if we consider them altogether, it is clear that it is possible that, if these opportunities had not been missed, the outcome for Catherine may have been different.

- This review saw evidence of agencies, in some cases, appearing to work in isolation. There was information that was not known by all those engaged with Catherine and there are times when it appears that a number of agencies were seeking to support her in the same way. For example, Catherine indicated that she would consider seeing a solicitor to talk about applying for a non-molestation order. Two different agencies were supporting her with this by arranging appointments and attending with her. It is questionable how effective this would have been for Catherine and that closer liaison between agencies would have resulted in better co-ordinated support for Catherine and a more effective use of officer's time.

The Review has made the following 30 (thirty) recommendations across 8 organisations.

Metropolitan Police

1 That Greenwich BOCU SLT dip samples domestic incident reports to assess the effectiveness of investigative strategies and ensure opportunities are taken to pursue prosecutions in relation to coercive control.

2 That officers involved in this incident are debriefed regarding the requirement to update the DASH risk assessment when there is a change in circumstances, such as a release from custody.

3 That Greenwich BOCU SLT ensure that there is a pathway for the transfer of information about domestic abuse victims and perpetrators to housing providers where cases fall below the MARAC threshold.

4 That officers receive refresher training in the use of the DASH Risk Assessment, particularly in relation to identifying coercion and control.

Royal Borough of Greenwich Council

5 That all housing staff receive up to date, and ongoing, training about domestic abuse in its broadest sense – coercion and control, economic abuse

6 That whenever a DVPO is granted and the victim is a tenant of the council, that a multi-agency meeting is called to discuss the housing options available to that person, with a view to moving them during this time of respite from the perpetrator.

7 That Tenancy Services adopt a checklist approach to complete as soon as a report of domestic violence is received to ensure that all the relevant questions are asked in relation to rehousing and an opportunity to protect a victim is not missed. The checklist could include, for example:
   - Refuge and/or temporary accommodation offered and the outcome, including the reason for non-acceptance
   - MARAC actions
   - Details about agencies working with the client
   - Police disclosure requests and responses
   - Date case review completed
   - Case Review Panel notes and the outcome
   - Emails and information from other agencies saved in case file

8 That frontline staff receive up to date information/training in order that they can promote this service and help to allay concerns that victims might have.

9 It is recommended that the Tenancy Department:

- Carries out an audit of all cases heard at MARAC over the past months to ensure that the correct information has been added to the tenant's account.
- Revisits how a domestic abuse flag is placed on a tenant's account making any changes needed to ensure that every time an account is visited the officer can clearly see that the person is a victim of domestic abuse.

GDVA

10 In line with the recommendation within the IMR produced by GDVA to this review, it is recommended that the lone working practices for staff working with those with complex needs are reviewed.

11 In order that all partners share a clear definition of complex needs for this client group, it is recommended that GDVA develops a definition of complex needs and consults with partners prior to its adoption by local agencies.

Oxleas NHS Foundation Trust

12 That the means for sharing information with partners when a client is discussed at MARAC is reviewed to ensure that information is passed on in a timely manner.

13 That an information sharing protocol is implemented with CGL (and other substance misuse service providers) to ensure that there is effective joint working with patients who have dual diagnosis. Such protocol needs to be cognisant of GDPR, balanced with the need for safeguarding considerations in certain cases.

14 That Oxleas staff should routinely use the recommended Alcohol Use Disorders Identification Test Consumption (Audit C) tool.

15 That the PCP team are reminded in team meetings and clinical supervision sessions where risk assessments should be documented.

16 Where complex psychosocial stressors are clearly identified the suitability for Brief Interventions should be carefully considered.

17 That practitioners 'job plans' identify the need to liaise and work with other services involved in a patient's care eg child and family services, dual diagnosis services and domestic abuse services.

GP Surgeries

18 That the GP surgery in question ensures that all practice staff understand what MARAC stands for and the level of risk associated with this.

19 That the GP surgery ensures that all practice staff receive domestic abuse training that is commensurate with their role.

CGL change grow live

20 That Recovery Plans incorporate goals relating to domestic abuse irrespective of whether this domestic abuse is being managed by another service.

21 That a multi-disciplinary meeting is called in relation to all clients who are experiencing domestic abuse.

22 That a re-engagement plan that is to be used when a client disengages, should be created in collaboration with partner agencies for all clients who are also accessing domestic abuse services.

23 That all clients experiencing domestic abuse are routinely discussed in clinical meetings.

Greenwich MARAC

24 That the means for sharing information with partners when a client is discussed at MARAC is reviewed to ensure that information is passed on in a timely manner.

25 That GP surgeries are routinely advised when their patients are to be discussed at MARAC and that the notes of the meeting are forwarded to them.

26 That MARAC ensures that it has named contacts at all agencies within the Borough so that requests are not sent to generic email addresses. This will reduce the opportunity for requests to be missed or misunderstood.

27 That a leaflet is designed that explains about MARAC – what it is and what actions from MARAC are likely to be requested. This leaflet should then be sent to agencies such as GPs whose involvement with MARAC is occasional so that they fully understand what, and why, they are being asked to do.

28 That a box is added above the actions box to record the risks identified during the meeting and actions that are being taken to mitigate the risks.

29 That updates are recorded below the action to make the minutes clearer and easier to follow, particularly if they are being read by someone who is not familiar with MARAC or was not at the meeting.

Royal Borough of Greenwich Community Safety Partnership

30 That the partnership reviews the potential for the use of civil injunctions to provide the protection that victims need in other cases and agrees a protocol for such applications

All of those officers involved in this review were touched by the circumstances and our thoughts are with Catherine's family, in particular her children.